Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

2022 Community Health Needs Assessment

Acknowledgments

This 2022 Community Health Needs Assessment (CHNA) report for Beth Israel Deaconess Medical Center (BIDMC) is the culmination of a collaborative process that began in September 2021. At the foundation of this endeavor was a desire to meaningfully engage and gather important input from residents, community-based organizations, clinical and social service providers, public health officials, elected/appointed officials, medical center leadership, and other key collaborators throughout the medical center's Community Benefits Service Area. Substantial efforts were made to ensure that all segments of the community had the opportunity to participate, with an intentional focus on engaging cohorts who have been historically underserved.

BIDMC, including the BIDMC Community Benefits Advisory Committee (CBAC) which oversaw the CHNA process, extends its sincere appreciation to everyone who invested time, effort, and expertise to ensure the development of the medical center's CHNA and Implementation Strategy (IS).

BIDMC thanks the Steering Committee of the Boston Community Health Needs Assessment (CHNA)-Community Health Improvement Plan (CHIP) Collaborative (Boston CHNA-CHIP Collaborative) for their collaboration in this assessment process. The Boston CHNA-CHIP Collaborative, comprised of teaching hospitals and medical centers in the Boston area, community health centers, the Boston Public Health Commission, community-based organizations, and residents, hired Health Resources in Action to support their effort. The Steering Committee engaged the City of Boston's Human Services Department to serve as a backbone organization to the CHNA and IS with a specific focus on providing coordination on execution of the IS. Per federal and Commonwealth requirements, local health departments must be involved in CHNA activities, and the Boston Public Health Commission more than fulfilled this requirement. Special thanks are also due to the North Suffolk Integrated Community Health Needs Assessment initiative for their support and their contributions to this assessment.

Beth Israel Deaconess Medical Center 2022 Community Benefits Advisory Committee

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It should be noted that the CHNA and IS were greatly informed and supported by staff and clinicians at the community health centers who are part of Beth Israel Lahey Health's Community Care Alliance. These health centers are a significant part of Boston's health care safety net and do excellent work on behalf of Boston's most historically underserved populations.

Finally, BIDMC's Community Benefits staff and senior leadership acknowledge the great work, support, and commitment of the BIDMC CBAC. The CBAC is comprised of community members, clinical and social service providers, and other key stakeholders that live and/or work in BIDMC's Community Benefits Service Area. The CBAC oversaw every aspect of the needs assessment. The work of the CBAC has strengthened BIDMC's connections with the people and the communities it serves.

Boston CHNA-CHIP Collaborative Steering Committee

Mary Ellen McIntyre (co-chair), Massachusetts League of Community Health Centers

Magnolia Contreras (co-chair), Dana-Farber Cancer Institute

Leslie Aldrich, Massachusetts General Hospital

Emilio Dorcely, Urban Edge

Sherry Dong, Tufts Medical Center

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Michelle Keenan, Brigham and Women's

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Tavinder Phull, MassGeneralBrigham

Leslie Reid, Madison Park Development Corporation

Tracy Mangini Sylven, Brigham and Women's Faulkner Hospital

North Suffolk Integrated Community Health Needs Assessment Steering Committee

Municipal Leadership:

City of Chelsea

City of Revere

City of Winthrop

North Suffolk Public Health Collaborative

Community Organizations:

Community Action Programs Inter-City, Inc.

For Kids Only

Healthy Chelsea

Mystic Valley Elder Services

The Neighborhood Developers

Revere CARES

Winthrop CASA

Health Care Providers:

Beth Israel Deaconess Medical Center

Cambridge Health Alliance

East Boston Neighborhood Health Center

Massachusetts General Hospital

MelroseWakefield Healthcare

North Suffolk Mental Health Association

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Introduction

Background

Beth Israel Deaconess Medical Center (BIDMC) is one of the nation's preeminent academic medical centers and is nationally recognized for its world-class clinical expertise, education, and research. In 2019, as part of a merger of two health systems in the greater Boston region, BIDMC became part of Beth Israel Lahey Health (BILH) - a system of academic medical centers, teaching hospitals, community hospitals, and specialty hospitals with more than 35,000 caregivers and staff who are collaborating in new ways across professional roles, sites of care, and regions to make a difference for patients, communities, and one another. BIDMC is one of BILH's premier institutions, with 673 licensed beds and over 1,200 active physicians. The medical center is also a Level 1 trauma center with a full range of medical/surgical, critical care, OB/GYN, and emergency services, and an extensive network of primary care and outpatient specialty care practices. BIDMC prides itself on its ability to combine exceptional and compassionate patient care with advanced medical knowledge, research, and technology in ways that allow it to achieve the best outcomes for its patients. BIDMC, in partnership with the BILH system, is committed to providing the very best care and strives to improve the health of the people and families in its Community Benefits Service Area (CBSA).

This 2022 Community Health Needs Assessment (CHNA) report is an integral part of BIDMC's population health and community engagement efforts. It supplies vital information that is applied to make sure that the services and programs that BIDMC provides are appropriately focused, delivered in ways that are responsive to those in its CBSA, and address unmet community needs. This assessment, along with the associated prioritization and planning processes, also provides a critical opportunity for BIDMC to engage the community and strengthen the community partnerships that are essential to its success now and in the future. The assessment engaged thousands of people from across the CBSA, including local public health officials, clinical and social service providers, community-based organizations, first responders (e.g., police, fire department, and ambulance officials), other government officials, faith-based leaders, and community residents.

The process that was applied to conduct the CHNA and develop the associated Implementation Strategy (IS) exemplifies the spirit of collaboration and community engagement that is such a vital part of BIDMC's mission.

Finally, this report allows BIDMC to meet its federal and Commonwealth community benefits requirements per the federal Internal Revenue Service, as part of the Affordable Care Act, the Massachusetts Attorney General's Office, and the Massachusetts Department of Public Health.

Purpose

The CHNA is at the heart of BIDMC's commitment to promoting health and well-being, addressing health disparities, and working to achieve health equity. Health equity - the attainment of the highest level of health for all people - requires focused and ongoing efforts to address the inequities and socioeconomic barriers to accessing care, and the current and historical discrimination and injustices that underlie existing disparities. Throughout the assessment process, efforts were made to understand the needs of the communities that BIDMC serves, especially the population segments that are often disadvantaged, face disparities in health-related outcomes, and who have been historically underserved.

BIDMC completed its last CHNA in 2019 and the report, along with the associated 2020-2022 IS, was approved by the BIDMC Board of Trustees on September 18, 2019. The 2019 CHNA report was posted on BIDMC's website before September 30, 2019 and, per federal compliance requirements, made available in paper copy, without charge, upon request. The assessment and planning work for this current report was conducted between September 2021 and September 2022, and BIDMC's Board of Trustees approved the 2022 CHNA report and adopted the 2023-2025 IS, included as Attachment E, on September 21, 2022.

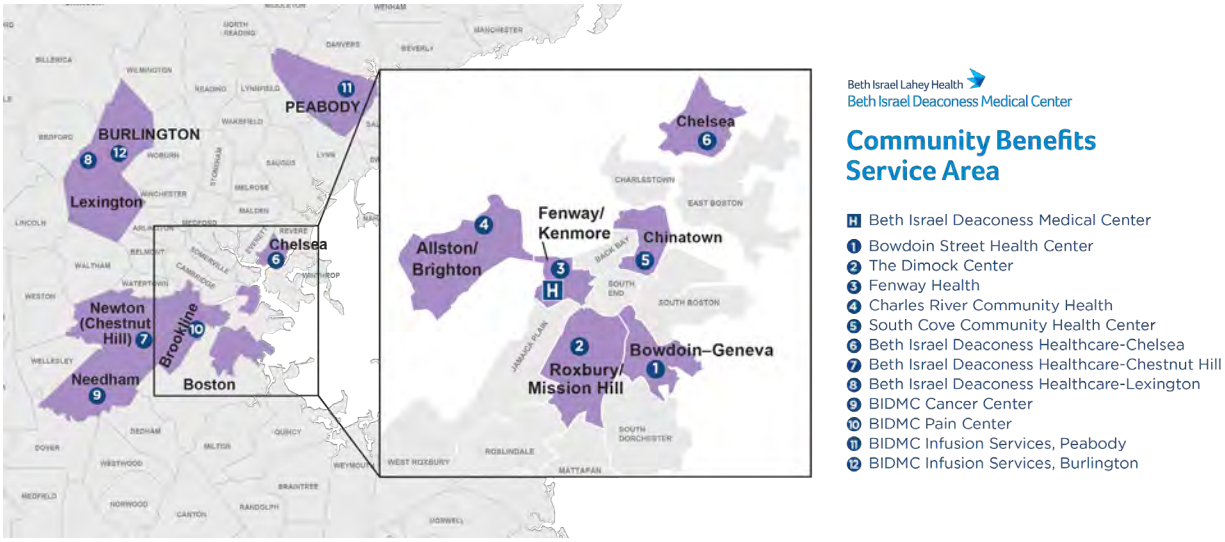
Definition of Community Served

The federal government and the Commonwealth require that nonprofit hospitals engage their communities and conduct comprehensive CHNAs that identify the leading health issues, barriers to care, and service gaps for people who live and/or work within the medical center's designated CBSA. Understanding the geographic and demographic characteristics of BIDMC's CBSA is critical to recognizing inequities, identifying priority cohorts, and developing focused strategic responses.

Description of Community Benefits Service Area

BIDMC's main campus is in the Longwood Medical Area of Boston, where it operates a Level 1 trauma center and provides a full range of medical, surgical, critical care, OB/GYN, and emergency services. In addition to the medical center facility in the Longwood area, BIDMC operates licensed multi-specialty outpatient facilities in Chelsea, Lexington, and Chestnut Hill*, the BIDMC Cancer Center in Needham, the BIDMC Pain Center in Brookline, and infusion centers in Burlington and Peabody. BIDMC also operates a licensed health center in Bowdoin/Geneva and has strong, long-standing partnerships with five Federally Qualified Health Centers (FQHCs). Four of these FQHCs – Charles River Community Health, The Dimock Center, Fenway Health, and South Cove Community Health Center – are located in BIDMC's CBSA and the fifth - Outer Cape Health Services – is in Barnstable County, Massachusetts. These FQHCs are key community benefits partners as they are rooted in their communities and are dedicated to treating those who are historically underserved. These FQHCs have been a vital part of BIDMC's community health strategy since 1968, when the medical center first joined forces with

*Chestnut Hill – a village west of Boston – is located partially within Brookline and partially within Newton. Throughout this report, data for Brookline and Newton are included if data was unavailable for Chestnut Hill.



The Dimock Center to address maternal and child health issues.

BIDMC's CBSA does not include a contiguous set of geographic communities. Rather, per federal requirements, it is defined as the cities and towns that are part of the Community Care Alliance and/or where BIDMC operates licensed facilities. BIDMC's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within its CBSA. In recognition of the considerable health disparities that exist in some communities in its CBSA, BIDMC focuses the bulk of its community benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved living in the city of Chelsea and the Boston neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill, and Roxbury.

While there are segments of the populations in Brookline, Burlington, Chestnut Hill, Lexington, Needham, and Peabody who are vulnerable and have limited access to the care they need, the greatest disparities exist for those who live in Chelsea and the Boston neighborhoods that are part of the CBSA. By prioritizing these cohorts, BIDMC can promote health and well-being, address health disparities, and maximize the impact of its community benefits resources. Further, while BIDMC operates licensed facilities in Burlington, Needham and Peabody, these service locations are in other BILH CBSAs. The Town of Burlington and the City of Peabody are located within Lahey Hospital and Medical Center's (LHMC) CBSA and the Town of Needham is located within Beth Israel Deaconess-Needham's (BID Needham) CBSA. As a result, the community benefits activities for these municipalities have been delegated to LHMC and BID Needham. This helps to ensure that activities are properly coordinated and address the identified needs.

Assessment Approach & Methods

Approach

It would be difficult to overstate BIDMC's commitment to community engagement and a comprehensive, data-driven, collaborative, and transparent assessment and planning process. Rather than conducting a single assessment, BIDMC's Community Benefits staff, along with its CBAC, dedicated hours of their time and other resources to participate in and gather information from three concurrent assessments.

The first of these assessments was BIDMC's own CBSA assessment, which engaged local public health officials, clinical and social service providers, community-based organizations, first responders (e.g., police, fire department, and ambulance officials), faith leaders, government officials, and community residents. This CBSA assessment gathered quantitative and qualitative information from all of the municipalities that are part of BIDMC's CBSA.

In addition to its own CBSA assessment, BIDMC's Community Benefits staff gathered information from two other assessments conducted by organizations or collectives of organizations in Boston and/or Chelsea: 1) The Boston Community Health Needs Assessment-Community Health Improvement Plan Collaborative (Boston CHNA-CHIP Collaborative), and 2) The North Suffolk Community Needs Assessment.

- **The Boston CHNA-CHIP Collaborative**, consisting of Boston's hospitals and community health centers, the Boston Public Health Commission, community-based organizations, and community residents, conducted a robust and collaborative community health needs assessment for the City of Boston as a whole. Facilitated through the Conference of Boston Teaching Hospitals (COBTH) and the City of Boston's Human Services Department, the Boston CHNA-CHIP Collaborative assessment focused on the social determinants of health through the lens of health equity; it aimed to uncover and understand how and why individuals in certain Boston neighborhoods or population groups experience inequities in health outcomes and barriers to care based on socioeconomic status, race and ethnicity, language, health status, sexual orientation, gender identity, and other factors. The overall approach was participatory and collaborative, engaging community residents throughout the CHNA process. Nancy Kasen, Beth Israel Lahey Health's Vice President of Community Benefits and Community Relations, served as the founding Co-Chair of the Boston CHNA-CHIP Collaborative Steering Committee and continues to serve on its Steering Committee and workgroups. Robert Torres, BILH's Director of Community Benefits for the Boston region, served as the Co-Chair of the Community Engagement Workgroup for the 2022 CHNA.
- **The North Suffolk Public Health Collaborative Community Needs Assessment** was a comprehensive assessment and planning effort which gathered information from a broad geographic area to the north of Boston, including Chelsea. The assessment was overseen by a steering committee comprised of municipal leaders, community organizations, and representatives from the five health systems that serve the North Suffolk region. Kelina Orlando, BIDMC Executive Director of Ambulatory Operations served on the assessment's Steering Committee and participated in the primary data collection process. The Steering Committee was responsible for monitoring the completion of assessment tasks, coordinating communication efforts with key partners and the public-at-large, and making final decisions on priority areas and strategies. Robert Torres, BILH's Director of Community Benefits for the Boston region, and Danelle Marable, BILH's Director of Data and Evaluation for Community Benefits and Community Relations, worked with the Steering Committee to help design data collection tools. The assessment was comprehensive in nature, including quantitative data and information gathered from a series of community meetings led by the City of Chelsea on how best to use funds from the American Rescue Plan Act of 2021 (ARPA). Qualitative information was gathered through a survey, which collected information from more than 493 respondents in Chelsea, focus groups, and interviews. In total, the assessment effort included 6 focus groups with service providers in Chelsea and 29 in-depth interviews with key stakeholders. The Steering Committee worked with the Metropolitan Area Planning Council to identify key assessment findings, identify community health priorities and priority populations for investment, and develop the CHNA report and a community health improvement plan (CHIP). Additional information on the North Suffolk Community Needs Assessment is provided in Appendix A.

BIDMC also participated in the BILH CHNA process and collaborated with Beth Israel Deaconess Hospital-Needham (BID Needham), Lahey Hospital & Medical Center (LHMC), and New England Baptist Hospital (NEBH). With respect to BID Needham, BIDMC and BID

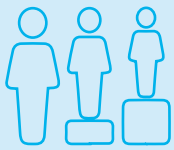
Needham both include Needham in their CBSAs. With respect to LHMC, BIDMC and LHMC both include Burlington and Peabody in their CBSAs. With respect to NEBH, BIDMC and NEBH both include Mission Hill, Chestnut Hill, and Brookline in their CBSAs. BIDMC shared the information they gathered on these overlapping neighborhood, cities and towns with its other BILH hospital partners as part of its processes. It should be noted that the collaborative activities referenced above were bi-directional, meaning that each institution shared quantitative and qualitative findings that they gathered on the overlapping neighborhoods and municipalities with the other institutions. Involvement in these concurrent efforts allowed BIDMC and the other hospitals involved to fully leverage the breadth of resources being invested across their CBSA to understand community need and system capacity, while not unduly burdening the community. This involvement also facilitated important and valuable collaboration between BIDMC and the other health service organizations outside of the CHNA process.

Finally, BIDMC also integrated the extensive, ongoing community engagement and planning that the medical center is conducting as part of its Massachusetts Determination of Need New Inpatient Building Community-based Health Initiative. These activities focused on the Boston neighborhoods that are part of BIDMC's CBSA.

Since this work began in 2019, BIDMC's Community Benefits staff have conducted a broad range of community engagement activities, including a series of community listening sessions that gathered information from residents in each of the six neighborhoods in Boston that are part of BIDMC's CBSA.

Combined, these efforts helped to ensure that a sound, objective, and inclusive CHNA process was conducted across BIDMC's entire CBSA. This process involved extensive data collection activities, substantial efforts to engage BIDMC's partners and community residents, and thoughtful prioritization, planning, and reporting processes. Special care was taken across all the assessment's individual components to include the voices of community residents who have been historically underserved, such as those who are unstably housed or homeless, those who do not speak English, those who are recent immigrants, those who are in substance use recovery, and those who experience barriers and disparities due to their race, ethnicity, gender identity, age, disability status, or other personal characteristics.

The CHNA and IS development process was guided by the following principles: equity, collaboration, engagement, capacity building, and intentionality.

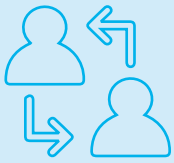


Equity:

Work toward the systemic, fair, and just treatment of all people.

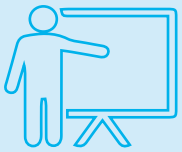
Collaboration:

Leverage resources to achieve greater impact by working with community residents and organizations.



Engagement:

Intentionally outreach to and interact with hardly reached populations; including but not limited to people impacted by trauma, people with disabilities, people most impacted by inequities, and others.



Capacity Building:

Build community cohesion and capacity by co-leading community listening sessions and training community residents on facilitation.

Intentionality:

Be deliberate in requests for and use of data and information; be purposeful and work collaboratively to identify and leverage resources for maximum benefit.

The BIDMC CHNA and planning process was conducted between September 2021 and September 2022 in three phases, which are detailed in the table below.

Phase I: Preliminary Assessment & Engagement	Phase II: Focused Engagement	Phase III: Strategic Planning & Reporting
Engagement of existing CBAC	Additional interviews	Presentation of findings and prioritization with CBAC and hospital leadership
Collection and analysis of quantitative data	Facilitation of focus groups with community residents and community-based organizations	Draft and finalize CHNA report and IS document
Interviews with key collaborators	Dissemination of community health survey, focusing on resident engagement	Presentation of final report to CBAC and hospital leadership
Evaluation of community benefits activities	Facilitation of community listening sessions to present and prioritize findings	Presentation to BIDMC's Board of Trustees
Preliminary analysis of key themes	Compilation of resource inventory	Distribution of results via BIDMC's website

In July of 2021, BIDMC hired John Snow, Inc. (JSI), a public health consulting firm based in Boston, to integrate the information gathered across these concurrent assessments and augment the information gathered, where appropriate. BIDMC worked with JSI to ensure that the final BIDMC CHNA engaged the necessary community constituents, incorporated comprehensive quantitative information for all communities in its CBSA, and fulfilled federal and Commonwealth community benefits requirements.

Methods

Oversight and Advisory Structures

The CBAC greatly informs BIDMC's assessment and planning activities. BIDMC's CBAC is made up of staff from the medical center's Community Benefits Department, other medical center administrative/clinical staff, and members of the medical center's Board of Trustees. Perhaps more importantly, the CBAC includes representatives from:

- Additional municipal staff (such as elected officials, planning, etc.)
- Education
- Community Health Centers
- Housing (such as community development corporations, local public housing authority, etc.)
- Local Public Health Departments/Boards of Health
- Regional planning and transportation agencies
- Social services
- Private sectors
- Community-based organizations.

These institutions are committed to serving residents throughout the CBSA and are particularly focused on meeting the needs of those who are medically underserved, those experiencing poverty, and those who face inequities due to their race, ethnicity, spoken language, national origin, religion, gender identity, sexual orientation, age, disability status, immigration status, or other personal characteristics.

The involvement of BIDMC's staff in the CBAC promotes transparency and communication and ensures that there is a direct link between BIDMC and many of the community's leading health and social service community-based organizations. The CBAC meets quarterly to support BIDMC's community benefits work and met six times during the CHNA and planning process. During these meetings, the CBAC provided valuable input on the assessment approach and community engagement strategies, vetted preliminary findings, and helped to prioritize community health issues and the cohorts experiencing or at-risk for health inequities. All BIDMC CBAC meetings are open to the public and the CBAC welcomes oral and written comments.

Quantitative Data Collection

To meet the federal and Commonwealth community benefits requirements, BIDMC collected a range of quantitative data to characterize the communities in its CBSA. BIDMC also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data was collected for specific geographic, demographic, or socioeconomic segments of

the population to identify disparities and clarify the needs for specific communities. The data was tested for statistical significance whenever possible and compared against data at the regional, Commonwealth, and national levels to support analysis and the prioritization process. The assessment also included data compiled at the local level from school districts, police/fire departments, and other sources. A databook that includes all the quantitative data gathered for this assessment is included in Appendix B.

Every effort was made to leverage any data that could be brought to bear on BIDMC's CBSA. However, this methodology highlighted the limitations that the assessment faced due to gaps in the availability of Boston data at the neighborhood-level.

Demographic, SES* & SDOH** Data	Commonwealth/National Health Status Data	Hospital Utilization Data	Municipal Data Sources
Age, SOGI***, race, ethnicity	Vital statistics	Inpatient discharges	Public school districts
Poverty, employment, education	Behavioral risk factors	Emergency department discharges	Local assessments and reports
Crime/violence	Disease registries		
Food access	Substance use data		
Housing/transportation	COVID-19 Community Impact Survey		

*Socioeconomic status **Social determinants of health ***Sexual orientation and gender identity

Community Engagement and Qualitative Data Collection

Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing cohorts most at-risk, and crafting a collaborative, evidence-informed IS. Accordingly, BIDMC applied Massachusetts Department of Public Health's Community Engagement Standards for Community Health Planning to guide engagement.[1]

To meet these standards, BIDMC employed a variety of strategies to help ensure that community members were informed, consulted, involved, and empowered throughout the assessment process. Across all four components, the assessment included 85 one-on-one interviews with key collaborators in the community, 22 focus groups with segments of the population facing the greatest health-related disparities, and community listening sessions that engaged 226 participants. In addition, BIDMC's BILH partners, BID Needham and LHMC, conducted a community health survey, which gathered information from more than 1,400 community residents from BID Needham's and LHMC's CBSAs, including 346 residents from Needham, 155 residents of Burlington, and 180 residents of Peabody. BID Needham and LHMC shared this information with BIDMC.

The Boston Public Health Commission fielded a COVID-19 Health Equity Survey in December 2020/January 2021; as such, BIDMC, based on recommendations from the Boston CHNA-CHIP Collaborative Steering Committee, opted not to field the BILH Community Health Survey in Boston. This survey of a random sample of over 1,650 residents in multiple languages examined issues related to job loss, food insecurity, access to services, mental health, vaccination, and perceptions of risk around COVID-19.

The North Suffolk Public Health Collaborative also fielded a community health survey. The survey collected data from 1,401 respondents from Chelsea, Revere, and Winthrop. Results were stratified by community, age group, gender, race, ethnicity, and language.

Appendix A of this report contains a comprehensive community engagement summary detailing how these activities were conducted, who was involved and what was learned. Also included in Appendix A are copies of the interview, focus group, and listening session guides, summaries of findings, and other related materials. Survey materials for the BILH Community Health Survey and the North Suffolk Public Health Collaborative are included in Appendix B.

Inventory of Community Resources

Community Benefits staff created a resource inventory of services available to address community needs. The inventory includes resources across the broad continuum of services, including:

- Domestic violence
- Food assistance
- Housing
- Mental health and substance use
- Senior services
- Transportation.

The resource inventory was compiled using information from existing resource inventories and partner lists from BIDMC. Community Benefits staff reviewed BIDMC's prior annual report of community benefits activities submitted to the Massachusetts Attorney General's Office, which included a listing of partners, as well as publicly available lists of local resources. The goal of this process was to identify key partners who may or may not be already collaborating with BIDMC or working to address identified needs in BIDMC's CBSA. The resource inventory can be found in Appendix C.

Prioritization, Planning, and Reporting

At the outset of the strategic planning and reporting phase of the project, community listening sessions were organized with the public-at-large, including community residents, representatives from clinical and social service providers, and other community-based organizations that provide services throughout the CBSA. This was the first step in the prioritization process and allowed the community to discuss the assessment's findings and formally prioritize the issues that they believed were most important, using an interactive and anonymous polling software. These sessions also allowed participants to share their ideas on existing community assets and strengths, as well as the services, programs, and strategies that should be implemented to address the issues identified.

After the community listening sessions, the BIDMC CBAC was engaged. The CBAC was updated on assessment progress and was provided the opportunity to vet and comment on preliminary findings. The CBAC then participated in their own prioritization process using the same set of interactive and anonymous polls, which allowed them to identify a set of community health priorities and the cohorts that they believed should be considered for prioritization as the medical center developed its IS.

After the prioritization process, a CHNA report was developed and the medical center's existing IS was augmented, revised, and tailored. In developing the IS, BIDMC's Community Benefits staff took care to retain the community health initiatives that worked well and that aligned with the identified priorities from the 2022 assessment, but also posed strategies to address the newly identified priorities.

The Boston CHNA-CHIP Collaborative also conducted an extensive series of prioritization and planning meetings to facilitate the development of a city-wide Community Health Improvement Plan (CHIP). The Boston CHNA-CHIP Collaborative developed a summary and full report of findings, which was extensively referenced to develop this report. The full Boston CHNA-CHIP Collaborative report is provided in Appendix A.

After drafts of the CHNA report and IS were developed, they were shared with BIDMC's senior leadership team for input and comment. BIDMC Community Benefits staff then reviewed these inputs and incorporated elements, as appropriate, before the final 2022 CHNA report and 2023-2025 IS were submitted to BIDMC's Board of Trustees for approval.

After the Board of Trustees formally approved the 2022 CHNA report and adopted the 2023-2025 IS, these documents were posted on BIDMC's website, alongside the 2019 CHNA report and 2020-2022 IS, for easy viewing and download. As with all BIDMC CHNA processes, these documents are made available to the public whenever requested, anonymously and free of charge. It should also be noted that BIDMC's Community Benefits staff have mechanisms in place to receive written comments on the most recent CHNA and IS, although no comments have been received since the last CHNA and IS were made available.

Questions regarding the 2022 assessment and planning process or past assessment processes should be directed to:

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Assessment Findings

This section provides a comprehensive review of the findings from this assessment. This section draws on quantitative data from a variety of sources and qualitative information collected from local public health officials, clinical and social service providers, community-based organizations, first responders (e.g., police, fire department and ambulance officials), faith leaders, other government officials, and community residents engaged in supporting the health and well-being of residents throughout BIDMC's CBSA. Findings are organized into the following areas:

- **Community Characteristics**
- **Social Determinants of Health**
- **Systemic Factors**
- **Behavioral Factors**
- **Health Conditions.**

Each section begins with a highlight of key findings. This introduction is followed by graphs and other data visuals. It is important to note that these five sections do not review all of the findings collected during the assessment, rather they draw out the most significant drivers of health status and health disparities. A databook that includes all the quantitative data gathered for this assessment, along with materials related to interivews, focus groups, and listening sessions are included in Appendices A and B.

Please note:
Data has been reported for the Boston neighborhoods that are part of BIDMC's CBSA when possible. When data was not available at the neighborhood level, then data was reported for the City of Boston overall. It should also be noted that BIDMC's CBSA includes Chestnut Hill – a village west of Boston – which is located partially within Brookline and partially within Newton. Data for both municipalities were included in this report when data for Chestnut Hill was unavailable.

Community Characteristics

A description of the population's demographic characteristics and trends lays the foundation for understanding community needs and health status. This information is critical to recognizing health inequities and identifying communities and population segments that are disproportionately impacted by health issues and other social, economic, and systemic factors. This information is also critical to BIDMC's and its partners' efforts to develop its IS, as it must focus on specific segments of the population that face the greatest health-related challenges. The assessment gathered a range of information related to age, race/ethnicity, nation of origin, gender identity, language, sexual orientation, disability status and other characteristics.

Based on the assessment, the community characteristics that were thought to have the greatest impact on health status and access to care in the BIDMC CBSA were issues related to age, race/ethnicity, language, gender identity, immigration status, household composition, and economic security. There was consensus among interviewees, focus groups, and community listening session participants that people of color, recent immigrants, and non-English speakers were more likely to have poor health status and face systemic challenges accessing needed services than white, English speakers who were born in the United States. These segments of the population are impacted by language and cultural barriers that limit access to appropriate services, pose health literacy challenges, exacerbate isolation, and may lead to discrimination and disparities in access and health outcomes.

One issue to be noted was the lack of data available by gender identity and sexual orientation at the municipal or Commonwealth level. Research shows that those who identify as lesbian, gay, bisexual, transgender, and/or queer/questioning experience health disparities and challenges accessing services.

Population Growth

Between 2010 and 2020, the population in BIDMC's CBSA increased by 9%, from 932,744 to 1,015,951 people. Chelsea saw the greatest percentage increase (16%), and Newton saw the lowest (4%).

Population Changes by Municipality, 2010 to 2020

Source: US Census Bureau Decennial Census 2010 and 2020

Nation of Origin

Immigration status is linked to health in many ways; individuals who are foreign-born are less likely to have access to healthcare and are more likely to forgo needed care due to fear of interacting with public agencies.[2]

Boston and Chelsea

28%

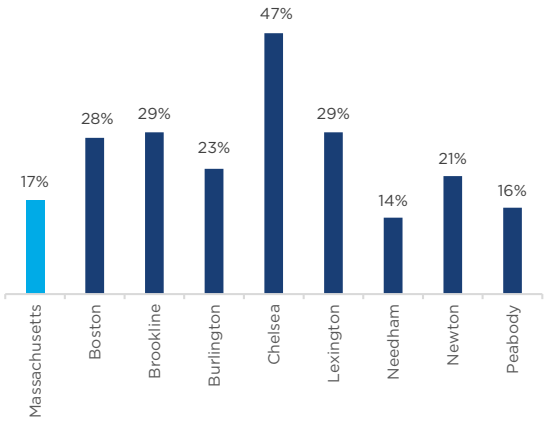
of Boston residents were foreign-born; among those, 50% were not US citizens.

47%

of Chelsea residents were foreign-born; among those, 68% were not US citizens. 86% of foreign-born residents in Chelsea were born in Latin America.

Source: US Census Bureau American Community Survey, 2016-2020

Percent of the Population That Were Foreign-Born, 2016-2020



Source: US Census Bureau American Community Survey, 2016-2020

Other Municipalities in the BIDMC CBSA

Among the other municipalities in the BIDMC CBSA, the percentage of the population that were foreign-born was significantly* higher than the Commonwealth, except for Needham, which had a significantly* lower percentage, and Peabody, where the percentage was similar.

*Statistically significant, as determined by margin of error provided by the US Census Bureau
Source: US Census Bureau American Community Survey, 2016-2020

Language

Language barriers pose major challenges to receiving and providing effective and high-quality health and social services. Studies show that health outcomes improve when patients and providers speak the same language.[3]

Boston and Chelsea

37%

of Boston residents 5 years of age and older spoke a language other than English in the home; of those, 17% had limited English proficiency.

71%

of Chelsea residents 5 years of age and older spoke a language other than English in the home; of those, 40% had limited English proficiency. Among non-English speakers, 61% spoke Spanish. Over a third (36%) of students in Chelsea Public Schools were English language learners.

Source: US Census Bureau American Community Survey, 2016-2020

Other Municipalities in the BIDMC CBSA

Compared to the Commonwealth, the percentage of residents 5 years of age and older who spoke a language other than English in the home was significantly* higher in Lexington (36%) and Brookline (33%), and significantly* lower in Needham (17%).

*Statistically significant, as determined by margin of error provided by the US Census Bureau
Source: US Census Bureau American Community Survey, 2016-2020

Age

Age is a fundamental factor to consider when assessing individual and community health status. Older individuals typically have more physical and mental health vulnerabilities and are more likely to rely on immediate community resources for support compared to young people.

Boston and Chelsea

The percentage of the population under 18 years of age was significantly* lower in Boston (16%) and significantly* higher in Chelsea (25%) compared to the Commonwealth overall (20%). The median ages in Boston (32) and Chelsea (34) were significantly* lower than the Commonwealth overall.

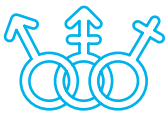
The percentage of the population over 65 years of age was significantly* lower in both Boston (12%) and Chelsea (10%) compared to the Commonwealth overall (17%).

Other Municipalities in the BIDMC CBSA

The median age was significantly* higher than the Commonwealth (40) in all other BIDMC CBSA municipalities, with the exception of Brookline (35), where the median age was significantly* lower. Among all municipalities, the median age was highest in Peabody (47).

*Statistically significant, as determined by margin of error provided by the US Census Bureau
Source: US Census Bureau American Community Survey, 2016-2020

Gender Identity and Sexual Orientation



Massachusetts has the second largest lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual (LGBTQIA+) population of any state in the nation. LGBTQIA+ individuals face issues of disproportionate violence and discrimination, socioeconomic inequality, and health disparities.

5% of adults in Massachusetts identify as LGBTQIA+. Data was not available at the municipal level.

21% of LGBTQIA+ adults in Massachusetts were raising children.

Source: Gallup/Williams 2019

Interviewees, focus groups, and listening session participants shared concerns around discrimination faced by the LGBTQIA+ population, especially transphobia. There was a need for affirming care that recognizes the impacts that gender identity and sexual orientation have on health and holistically attends to social, mental, and physical needs.

Boston and Chelsea

Approximately 8% of Boston adults identify as lesbian, gay, bisexual, or transgender; percentages in the neighborhoods that are part of BIDMC's CBSA were similar to the city overall: 7% in Fenway/Kenmore, 11% in Allston/Brighton, 7% in Roxbury, and 8% Dorchester.

Source: Boston Public Health Commission, 2018

Other Municipalities in the BIDMC CBSA

In a focus group with LGBTQIA+ individuals in the LHMC CBSA, participants shared that the top three factors that affected their health were a lack of affirming care, lack of support for LGBTQIA+ individuals in the community (leading to isolation and mental health issues), and personal health behaviors (e.g., eating unhealthy foods, lack of exercise, substance use).

Race and Ethnicity

In the BIDMC CBSA overall, the number of residents who identify as white and Black/African American decreased since 2010, while there was an increase in other census categories. Research illustrates the health disparities and differences in health care access and utilization that exist for diverse individuals and cohorts. The percentage of Black/African Americans who were uninsured was nearly double that of whites (10.6% vs. 5.9% white); Black/African Americans were also more likely to have reported fair or poor health compared to whites, and had the highest

mortality rate for all cancers among all racial and ethnic groups. Hispanic women were 40% more likely to have cervical cancer and 20% more likely to die from cervical cancer than non-Hispanic white women. Asian Americans were 40% more likely to be diagnosed with diabetes than non-Hispanic white Americans, and 80% more likely to be diagnosed with end-stage renal disease.[4] This data reinforced the importance of understanding the demographic makeup of a community to identify populations more likely to experience adverse health outcomes.

Boston and Chelsea

Both municipalities were diverse compared to the Commonwealth overall. Chelsea had the second highest percentage of Hispanic/Latino residents of all municipalities in the Commonwealth (68%). In Boston, the percentage of Black/African American (24%), Asian (10%), and Hispanic/Latino (20%) residents was significantly* higher than the Commonwealth overall.

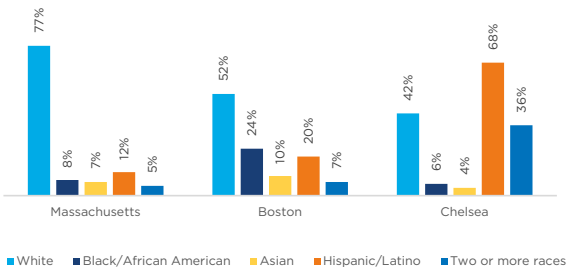
Other Municipalities in the BIDMC CBSA

In Brookline, Burlington, Lexington, and Newton, the percentage of the population that identified as Asian was significantly* higher compared to the Commonwealth.

Source: US Census Bureau American Community Survey, 2016-2020
*Statistically significant, as determined by margin of error provided by the US Census Bureau.

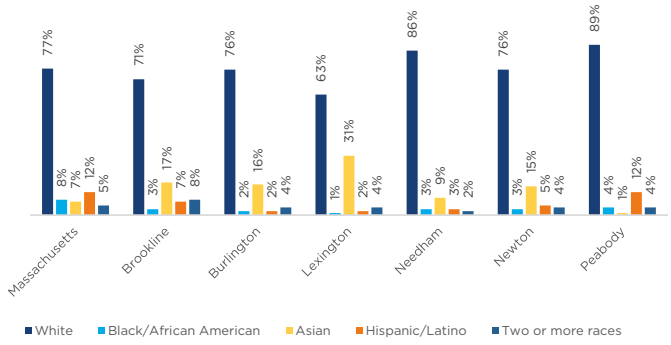
Note: The US Census Bureau reported that the 2020 Decennial Census significantly undercounted Black or African American, American Indian or Alaska Native, Some Other Race alone, and Hispanic or Latino populations. The Census significantly overcounted the white, non-Hispanic white, and Asian populations.

Race/Ethnicity of Residents in Boston and Chelsea, 2016-2020



Source: US Census Bureau American Community Survey 2016-2020

Race/Ethnicity of Community Residents, 2016-2020



Source: US Census Bureau American Community Survey , 2016-2020

Household Composition

Household composition and family arrangements may have significant impacts on health and well-being, particularly as family members act as sources of emotional, social, financial, and material support.[5]

Boston and Chelsea

Compared to the Commonwealth (29%), the percentage of households with one or more people under 18 years of age was significantly* lower in Boston (21%) and significantly* higher in Chelsea (36%). The percentage of households with an individual 65 years of age or older was significantly lower* compared to the Commonwealth (31%) in both cities.

Other Municipalities in the BIDMC CBSA

Compared to the Commonwealth (29%), the percentage of households with one or more people under 18 years of age was significantly* lower in Peabody (24%) and Brookline (25%), and significantly* higher in Lexington (44%), Newton (35%), and Needham (43%). The percentage of households with an individual 65 years of age or older was significantly* lower in Brookline (28%) and significantly* higher in Peabody (41%), Burlington (39%), Lexington (37%), Newton (35%), and Needham (38%).

Source: US Census Bureau American Community Survey, 2016-2020
*Statistically significant, as determined by margin of error provided by the US Census Bureau.

Social Determinants of Health

The social determinants of health are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[6] These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to housing, food insecurity, economic insecurity, education, access to care/navigation issues, and other important social factors.[6]

There was limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, surveys, and listening sessions reinforced that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food insecurity/nutrition, transportation, and economic stability.

Interviewees, focus groups, and listening session participants shared that access to safe and affordable housing was a challenge for many residents. This was particularly true for those experiencing poverty and those living on an inadequate fixed income. Participants also noted that there were individuals who were homeless or unstably housed in the BIDMC CBSA, particularly in Boston.

Interviewees, focus groups, and listening session participants identified food insecurity, hunger, and poor nutrition as challenges, particularly for individuals and families experiencing economic insecurity. These issues were largely driven by issues related to job loss, the inability to find employment that paid a livable wage, or living on an inadequate, fixed income, which impacted the ability of individuals and families to eat a healthy diet. In the suburban BIDMC CBSA municipalities, issues related to transportation were also identified as a critical barrier to maintaining one's health and accessing care, especially for those who do not have a personal vehicle or are without caregivers, family, and social support networks.

Finally, those participating in interviews, focus groups, and community listening sessions identified issues related to violence, including community violence, domestic violence, and child abuse/neglect. Beyond the physical health impacts for survivors, research shows that there are short- and long-term health impacts for those exposed to violence, including post-traumatic stress disorder and other mental health issues. Research shows that the death of a child was associated with a 21% increased risk of ischemic heart disease among parents.[7]

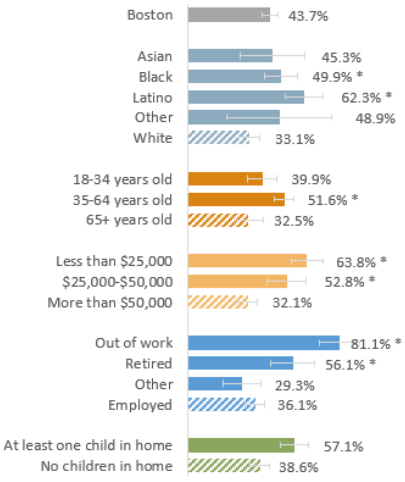
Other social factors that were highlighted in a more limited way during the assessment and thought to have an impact on health status and access to care were educational attainment and the built environment, including the importance of safe streets, sidewalks, and recreational areas.

Economic Stability

Economic stability is affected by income/poverty, financial resources, employment, and work environment, which allow people the ability to access the resources needed to lead a healthy life.[8] Lower-than-average life expectancy is highly correlated with low-income status.[9] Those who experience economic instability are more likely to be uninsured or to have health insurance coverage with limited benefits. Research has shown that those who are uninsured or have limited health insurance benefits are less likely to access health care services.[10]

COVID-19 exacerbated many issues related to economic stability; individuals and communities were impacted by job loss and unemployment, leading to issues of financial hardship, food insecurity, and housing instability. The Massachusetts Department of Public Health conducted the COVID-19 Community Impact Survey in the fall of 2020 to assess emerging needs, results of which indicated that community residents were concerned about their ability to pay their bills, especially in Boston, Chelsea, and Peabody.

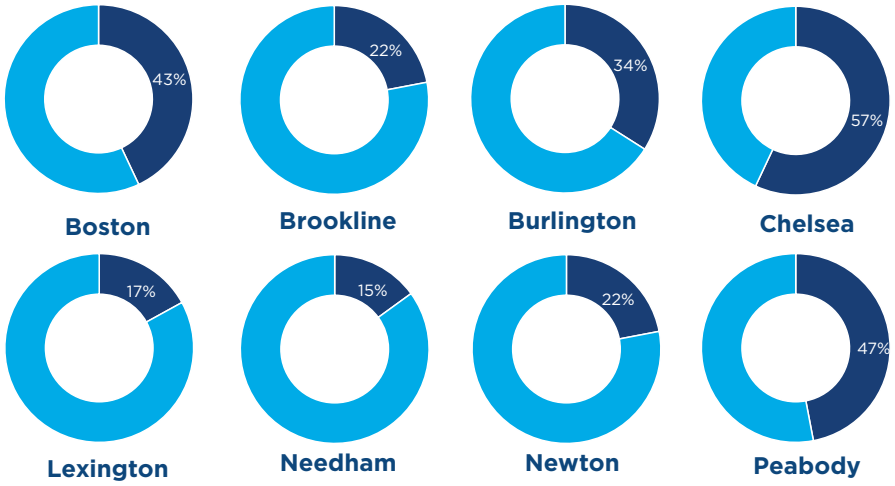
Percent of Adults Reporting Income Loss During COVID-19, December 2020-January 2021



NOTE: Graphic produced by the Boston Public Health Commission; percentage of adults reporting their household had significant loss of employment income since COVID-19. Bars with patterns indicate reference group for category. Asterisk (*) denotes where estimate was significantly different compared to reference group. Error bar shows 95% confidence interval.

Source: Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Questionnaire

Percentage* Worried About Paying 1 or More Types of Expenses/Bills in the Coming Weeks, Fall 2020



***Unweighted percentages displayed**

Source: MDPH COVID-19 Community Impact Survey, Fall 2020

Boston and Chelsea

The percentage of individuals living in poverty tended to be higher among non-white cohorts. Research shows that racial disparities in poverty are the result of systemic racism, discrimination, and cumulative disadvantage over time.[11]

4 in 10

Boston residents lost income over the pandemic; Black, Hispanic/Latino and low-resourced residents were most affected.

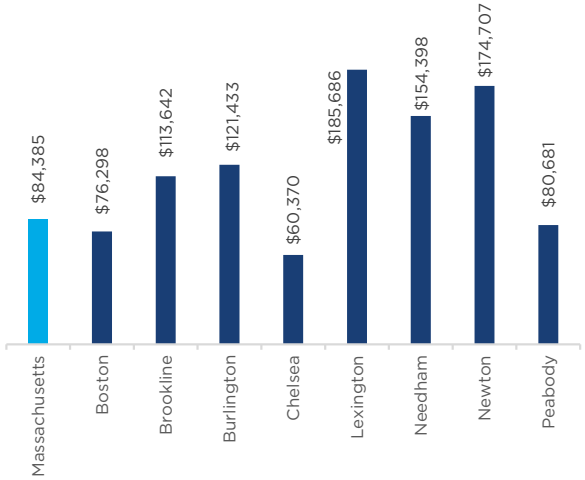
Source: Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Questionnaire

Other Municipalities in the BIDMC CBSA

Compared to the Commonwealth overall ($84,385), median household income was significantly* higher in Brookline, Burlington, Lexington, Needham, and Newton.

Source: US Census Bureau American Community Survey, 2016-2020
*Statistically significant, as determined by margin of error provided by the US Census Bureau.

Median Household Income, 2016-2020



Source: US Census Bureau American Community Survey, 2016-2020

Social Determinants of Health

Education

Research shows that those with more education live longer, healthier lives.[12] Patients with higher levels of educational attainment can better understand their health needs, follow instructions, advocate for themselves and their families, and communicate effectively with health providers.

Boston and Chelsea

Over half (51%) of Boston residents 25 years of age or older have a bachelor's degree or higher, which was higher than the Commonwealth overall (45%). Despite this, there were significant differences in educational attainment by race and ethnicity. Percentages were lower among non-white cohorts, with the exception of Asian residents (62%) compared to non-Hispanic white residents (48%), in the Commonwealth overall.

In Chelsea, the percentage of the population 25 years of age or older with a high school degree or higher (69%) was significantly* lower compared to the Commonwealth (91%).

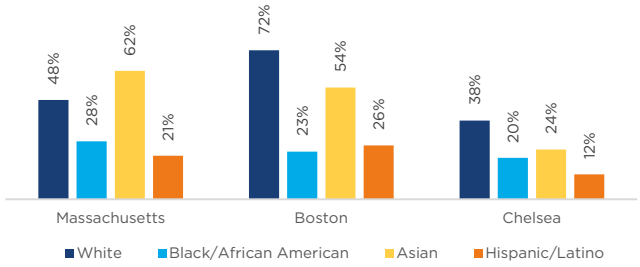
Compared to the Commonwealth overall (5%), the percentage of students in Boston (10%) and Chelsea public schools who drop out of school were higher (14%).

Other Municipalities in the BIDMC CBSA

The percentage of the population 25 years of age or older with a bachelor's degree or higher was significantly* higher than the Commonwealth overall (45%) in all municipalities except Peabody (35%), where the percentage was significantly* lower.

Source: US Census Bureau American Community Survey, 2016-2020
*Statistically significant, as determined by margin of error provided by the US Census Bureau.

Percentage of Residents 25 Years of Age and Older With a Bachelor's Degree or Higher, by Race/Ethnicity 2016-2020



Source: US Census Bureau American Community Survey, 2016-2020

Food Insecurity and Nutrition

Many families, particularly families who are low-resourced, struggle to access food that is affordable, high-quality, and healthy. Issues related to food insecurity and hunger are also factors contributing to poor physical and mental health for both children and adults. While it is important to have grocery stores placed throughout a community to promote access, there are other factors that influence healthy eating, including quality and price of fruits and vegetables, marketing of unhealthy food and cultural appropriateness of food offerings. Food pantries and community meal programs have evolved from providing temporary or emergency food assistance to providing ongoing support for individuals, families, seniors living fixed incomes, and people living with disabilities and/or chronic health conditions.

Food insecurity was one of the chosen priority areas for the City of Chelsea's American Rescue Plan Act (ARPA) funding.

Boston and Chelsea

Compared to the Commonwealth (12%), the percentage of households who received Supplemental Nutrition Assistance Program (SNAP) benefits in the past year was higher in Boston (17%) and Chelsea (20%).

During the COVID-19 pandemic, 21% of Boston residents reported food insecurity, compared to 18% pre-pandemic (2015-2019). Rates were highest among Black, Hispanic/Latino, low-income residents, and adults with children in the home.

Source: BPHC Boston BRFSS COVID-19 Health Equity Questionnaire

Other Municipalities in the BIDMC CBSA

Interviewees, focus groups, and listening session participants were concerned about food insecurity, especially for individuals with limited economic means, frail elders, individuals with chronic/complex conditions, and those without access to transportation. Over the course of the pandemic, many communities saw community partners come together to keep community members fed, including children who rely on school meal programs. Interviewees expressed a desire to see organizations and food pantries diversify offerings to include more culturally appropriate foods based on demographics, and explore ways to offer more fresh produce.

Neighborhood and Built Environment

The conditions and environment in which one lives have significant impacts on health and well-being. Access to safe and affordable housing, transportation resources, green space, sidewalks, and bike lanes improve health and quality of life.[13]

Housing

Lack of affordable housing and poor housing conditions contribute to a wide range of health issues, including respiratory diseases, lead poisoning, infectious diseases, and poor mental health.[14] At the extreme are those without housing, including those who are unhoused or living in unstable or transient housing situations who are more likely to delay medical care and have mortality rates up to four times higher than those who have secure housing.[15]

Interviewees, focus group participants, and survey respondents expressed concern over the limited options for affordable housing throughout BIDMC's CBSA – including urban and suburban municipalities.

Boston and Chelsea

Looking across occupied housing types (owner occupied with a mortgage, owner-occupied without a mortgage, and rented units), the percentage of units with housing costs that exceeded 35% of household income was higher than the Commonwealth in both Boston and Chelsea.

Housing was one of the chosen priority areas for the City of Chelsea's ARPA funding. Strategies include increasing new construction of affordable and mixed income housing, support for rent increase mitigation, housing vouchers, homeownership programs, and more.

4 in 10

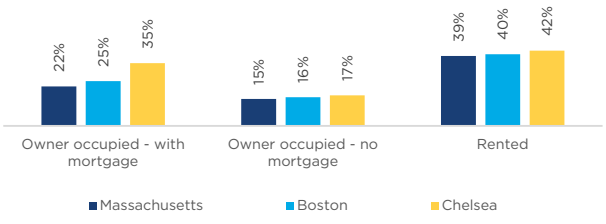
Boston adults reported trouble paying their rent or mortgage during the COVID-19 pandemic. Percentages were highest among Asian, Black, and Latino adults and adults with children in the home.

Source: BPHC Boston BRFSS COVID-19 Health Equity Questionnaire

54%

of Chelsea residents who responded to the North Suffolk Public Health Collaborative Community Survey indicated that "more affordable housing" was one of the top five things they'd like to see improve in their community.

Percentage of Housing Units with Housing Costs that Exceed 35% of Total Household Income, 2016-2020



Source: US Census Bureau American Community Survey, 2016-2020

Other Municipalities in the BIDMC CBSA

Among the other municipalities in BIDMC's CBSA, the percentage of owner-occupied units was significantly* higher compared to the Commonwealth overall (63%), except for Brookline (49%). Across communities, the percentage of cost burdened owner and renter occupied units were similar or significantly* lower compared to the Commonwealth.

Source: US Census Bureau American Community Survey, 2016-2020
*Statistically significant, as determined by margin of error provided by the US Census Bureau.

Transportation

Lack of transportation has impacts on access to health care services and is a determinant of whether an individual or family can access the basic resources that allow them to live productive and fulfilling lives. Access to affordable and reliable transportation widens opportunity and is essential to addressing poverty and unemployment; it allows access to work, school, healthy foods, recreational facilities, and other community resources.

Boston and Chelsea

Transportation was identified as a barrier to care and services for some segments of the population that may have difficulty accessing public transportation, including older adults and individuals with physical disabilities.

Chelsea focus group participants identified having access to the Massachusetts Bay Transit Authority (MBTA) buses as a resource and asset in their community.

Other Municipalities in the BIDMC CBSA

Many of the municipalities in BIDMC's CBSA have options for public transportation (e.g., buses, trains, commuter rail) in and out of Boston and other surrounding communities. In all communities except Lexington (7%), Peabody (3%), and Burlington (4%), the percentage of residents who utilized public transportation to commute to work was significantly* higher compared to the Commonwealth (9%). Interviewees, focus groups, and community listening session participants identified access to transportation as an issue in their community, especially for older adults without access to a personal vehicle or a caretaker.

Source: US Census Bureau American Community Survey, 2016-2020

*Statistically significant, as determined by margin of error provided by the US Census Bureau.

Built Environment

Creating safe outdoor spaces for people to commute, exercise, and relax is an important component in establishing healthy lifestyle habits that protect against poor health outcomes. While concerns related to the built environment were not key themes emerging from BIDMC's assessment, these issues can work to either prevent or contribute to disease and disability in the community.

Boston and Chelsea

Environmental health was identified as an American Rescue Plan Act priority area in the City of Chelsea. Strategies include increasing the amount of open space, parks, and active outdoor spaces, increasing street cleaning and sanitation, planting more trees, and developing a bike path to connect Chelsea to Boston.

Crime and Violence

Crime and violence, including domestic violence and intimate partner violence, are public health issues that influence health status on many levels, from death and injury to emotional trauma, anxiety, isolation, and absence of community cohesion.

Boston and Chelsea

In a focus group with individuals affected by violence and incarceration, participants shared the deep impacts and trauma imprinted on the community. Participants reported that there was a lack of empathy and support for communities and families, and expressed need for mental health support, peer programs, and more community organizations that focused on restorative justice, youth engagement, and mental health.

51%

of Chelsea residents who responded to the North Suffolk Public Health Collaborative Community Survey chose "lower crime and violence" as one of the top five things they'd like to improve in their community.

Other Municipalities in the BIDMC CBSA

Crime and violence were not critical concerns in any of the other municipalities in BIDMC's CBSA. Violent crime counts (e.g., aggravated assault) were low in all communities. Property crime counts (e.g., burglary, arson, larceny) were also low.

"We have the resources within us – supportive peer groups [should be] set up so that the community can be the resources."

– BIDMC focus group participant

Systemic Factors

In the context of the healthcare system, systemic factors include a broad range of different considerations that influence a person's ability to access timely, equitable, accessible, and high-quality services. There is a growing appreciation for the importance of these factors as they are seen as critical to ensuring that people can find, access, and engage in the services they need, communicate with clinical and social service providers, and transition seamlessly from one service setting to another. The assessment gathered information related to perceptions of service gaps, barriers to access (e.g., cost of care, health insurance status, language access, cultural competence), care coordination, and information sharing. The assessment also explored issues related to diversity, equity, and inclusion and the impacts of racism and discrimination.

Systemic barriers affect all segments of the population but have particularly significant impacts on people of color, non-English speakers, recent immigrants, individuals with disabilities, older adults, those who are uninsured, and those who identify as LGBTQIA+. Findings from the assessment highlighted the challenges that residents throughout the BIDMC CBSA faced with respect to long wait times, provider shortages, and service gaps which impacted people's ability to access services in a timely manner. This was particularly true with respect to primary care, behavioral health, medical specialty care, and dental care services.

Interviewees, focus groups, and listening session participants reflected on linguistic and cultural barriers to care. The assessment findings reinforced how difficult it was for many residents to schedule appointments, coordinate care, and find the services they needed, especially for individuals who speak languages other than English. Participants discussed the need for tools to address these issues, such as resource inventories, case managers, recovery coaches, and healthcare navigators.

Racial Equity

Racial equity is the condition where one's racial identity has no influence on how one fares in society.[16] Racism and discrimination influence the social, economic, and physical environments of Black, Indigenous, and People of Color (BIPOC), resulting in poorer social and physical conditions in those communities today.[17] Race and racial health differences are not biological in nature. However, generations of inequity contribute to differential health outcomes because of structural barriers and unequal distribution of resources.

"The inequities that have been impacting Black and Brown people are still happening today, over 18 months later [after the death of George Floyd]. We have corporations and government and city officials talking about these disparities in health access, in food, and in access to affordable and safe places to live."

- BIDMC interviewee

Boston and Chelsea

Interviewees, focus groups, and community listening session participants recognized the need for healthcare and community services that address racism, discrimination, and disparities in health access and outcomes. These disparities were further exposed by COVID-19, which disproportionately impacted communities of color. Experiencing racism and discrimination contributes to trauma, chronic stress and mental health issues that ultimately impact health outcomes.

28%

of Boston adults reported that they have received poor service at restaurants or stores in their day-to-day life due to their race and/or ethnicity. Compared to white residents (15%), percentages were significantly higher among Black (46%), Latino (38%), and Asian (35%) residents.

Source: BPHC Boston BRFSS COVID-19 Health Equity Questionnaire

Other Municipalities in the BIDMC CBSA

Racism and discrimination were recognized as critical community health issues in other BIDMC CBSA communities. Interviewees and focus groups identified the increasing diversity in their community as a critical strength.

Accessing and Navigating the Health Care System

Interviewees, focus groups, and community listening session participants identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, meaning that the issues stemmed from the way in which the system did or did not function. System-level issues included providers not accepting new patients, long wait lists, and an inherently complicated healthcare system that was difficult for many to navigate.

There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forego or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.[18]

Some providers began offering care via telehealth over the course of the pandemic to mitigate COVID-19 exposure and retain continuity of care. This strategy removed barriers for some but created new hardships for those who lacked technical resources or technical savvy to take advantage of such programs.[19]

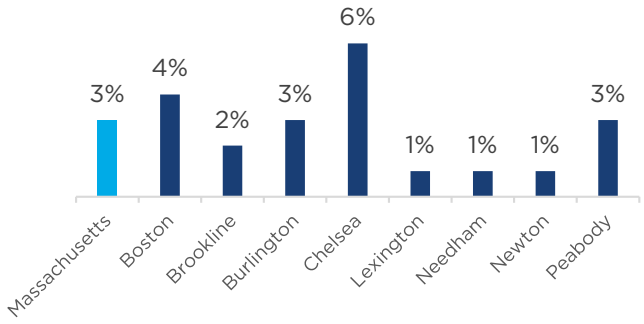
Boston and Chelsea

Compared to the Commonwealth (3%), the percentage of individuals who were uninsured was higher in Boston (4%) and Chelsea (6%).

Interviewees, focus groups, and community listening session participants identified a need for more diverse health care providers; research shows that patients experience fewer barriers to care when doctors reflect their own race or ethnicity.

Interviewees and focus groups also reported immigration status as a barrier to care – research shows that immigrants are more likely to forego needed health care and social services due to fear and uncertainty.

Percentage of Individuals Who Were Uninsured, 2016-2020



Source: US Census Bureau American Community Survey, 2016-2020

Other Municipalities in the BIDMC CBSA

Interviewees, focus groups, and community listening session participants reported that many residents found it difficult to navigate a complex healthcare system, including primary care, the behavioral health care system, health insurance, and specialty care. COVID-19 exacerbated barriers for many; wait times for appointments increased, and many providers stopped taking new patients.

Behavioral Factors

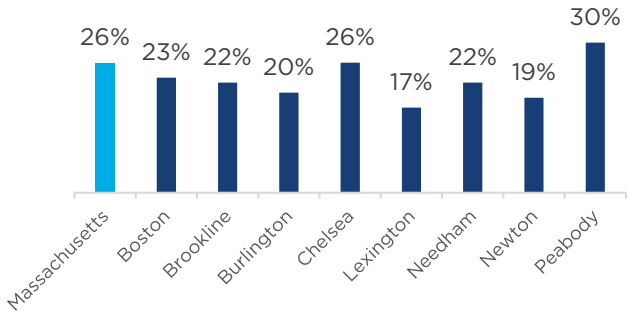
The nation, including the residents of Massachusetts and BIDMC's CBSA, face a health crisis due to the increasing burden of chronic medical conditions. Underlying these health conditions are a series of behavioral risk factors that are known to help prevent illness and are the early signs or contributors of the leading causes of death (e.g., heart disease, cancer, stroke, and diabetes). According to the National Centers for Disease Control and Prevention, the leading behavioral risk factors include an unhealthy diet, physical inactivity, and tobacco, alcohol, and marijuana use. Engaging in healthy behaviors and limiting the impacts of these risk factors is known to improve overall health status and well-being, and reduces the risk of illness and death due to the chronic conditions mentioned previously.[20]

When considering behavioral factors, the assessment reflected on a range of mostly quantitative information related to nutrition, physical activity, tobacco use, and alcohol use. Those who participated in the assessment's community engagement activities were asked to identify the health issues that they felt were most important. While these issues were ultimately not selected during BIDMC's prioritization process, the information from the assessment supports the importance of incorporating these issues in BIDMC's IS.

Nutrition

Adults who eat a healthy diet have increased life expectancy and decreased risk of chronic diseases and obesity; children require a healthy diet to grow and develop properly.[21] Access to affordable healthy foods is essential to a healthy diet. Access to opportunities for physical activity was not identified as a significant need in the BIDMC CBSA, though there was recognition that lack of physical fitness is a leading risk factor for obesity and several chronic health conditions.

Percentage of Adults Who Were Obese, 2018



Source: Behavioral Risk Factor Surveillance System, 2018

Boston and Chelsea

Compared to the Commonwealth (26%), the percentage of adults who were obese was lower in Boston (23%) and higher in Chelsea (26%).

Other Municipalities in the BIDMC CBSA

The percentage of adults who were obese was lower than the Commonwealth in all other BIDMC CBSA communities, with the exception of Peabody (30%).

Alcohol, Marijuana, and Tobacco Use

Though legal in the Commonwealth for those aged 21 and older, long-term and excessive use of alcohol, marijuana, and tobacco can lead to the development and exacerbation of chronic and complex conditions, including high blood pressure, cardiovascular disease, and cancer. Clinical service providers engaged in the assessment reported that increased stress and isolation over the course of the pandemic led to increases in substance use and relapse.

Boston and Chelsea

28%

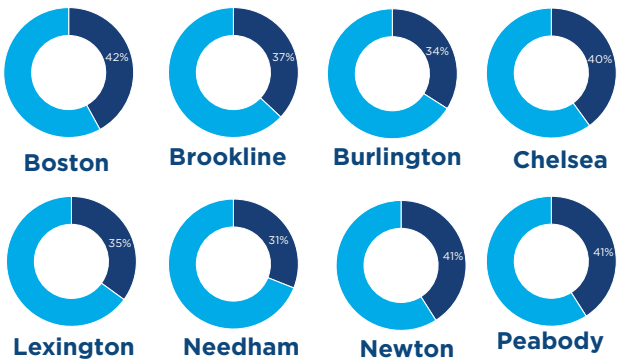
of Boston adults who consumed alcohol reported that their alcohol intake increased since March of 2020. The percentage was higher among LGBTQIA+ adults (41%).

Source: BPHC Boston BRFSS COVID-19 Health Equity Questionnaire

Other Municipalities in the BIDMC CBSA

In all BIDMC CBSA municipalities, with the exception of Needham, more than a third of respondents to MDPH's COVID-19 Community Impact Survey who were current substance users reported that they used more substances than before the pandemic.

Percentage Of Current Substance Users Who Said They Are Using More Substances Than Before the Pandemic, Fall 2020



Source: MDPH COVID-19 Community Impact Survey, Fall 2020

Health Conditions

The assessment gathered information related to the conditions that are known to be the leading causes of death and illness. These conditions include chronic and communicable medical conditions as well as mental health and substance use disorders. As discussed in the introductory sections of this report, the assessment gathered quantitative data to assess the extent that these issues were a concern in BIDMC's CBSA.

To augment and clarify this information, the assessment efforts included community engagement activities and specific requests for participants to reflect on the issues that they felt had the greatest impacts on community health. Efforts were made to ensure that participants reflected on a broad range of issues, including chronic and communicable medical conditions and behavioral health issues.

Given the limitations of quantitative data, specifically that it was often old data and was not stratified by race and ethnicity, the qualitative information from interviews, focus groups, and community listening sessions was of critical importance.

Mental Health

Anxiety, chronic stress, depression, and social isolation were leading community health concerns. There were specific concerns about the impact of mental health issues for youth and young adults; the mental health impacts of racism, discrimination, and trauma; and social isolation among older adults. These difficulties were exacerbated by COVID-19.

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services. Interviewees, focus groups, and community listening session participants also reflected on mental health stigma and the shame and isolation that those with mental health challenges face on a day-to-day basis that limits their ability to access care and cope with their illness.

Youth mental health was a concern in the BIDMC CBSA, including the prevalence of chronic stress, anxiety, and behavioral issues. These conditions were exacerbated throughout the pandemic, because of isolation, uncertainty, remote learning, and family dynamics.

Boston and Chelsea

The rate of inpatient discharges for individuals under 18 years of age for mental health conditions was higher than the state in both Boston and Chelsea - the rate in Chelsea was nearly double that of the Commonwealth.

17%

of Boston adults reported persistent sadness during the pandemic, and almost 22% reported persistent anxiety.

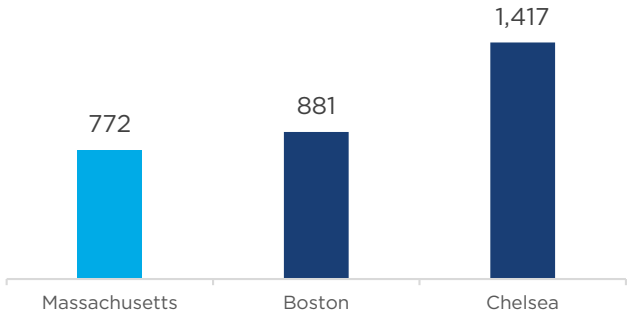
Source: BPHC Boston BRFSS COVID-19 Health Equity Questionnaire

Interviewees, focus groups, and community listening session participants identified a need for a more diverse mental health workforce. Research shows that culture has significant implications on how individuals view mental health issues and seek treatment.

"We need more mental health services that are not rooted in the white dominant culture, but that are rooted in people's cultural experiences."

-BIDMC interviewee

Inpatient Discharge Rates (per 100,000) for Mental Health Conditions Among Those Under 18 Years of Age, 2019



Source: Center for Health Information and Analysis, 2019

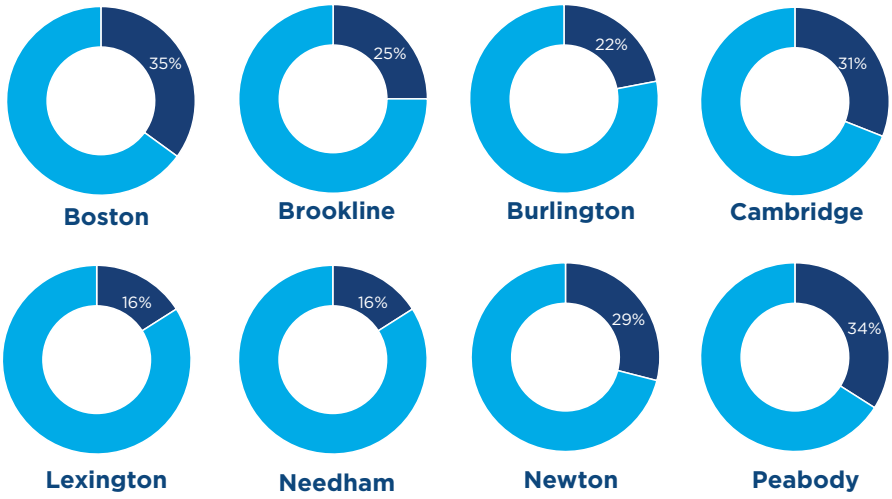
Mental health was one of the chosen priority areas for the City of Chelsea's American Rescue Plan Act (ARPA) funding.

Other Municipalities in the BIDMC CBSA

In most BIDMC CBSA communities, mental health emerged as the leading health concern. Interviewees, focus groups, and community listening session participants reported high prevalence of anxiety, depression, stress, and social isolation among older adults.

In all communities except Lexington and Needham, more than 20% of respondents to the MDPH COVID-19 Community Impact Survey reported poor mental health for at least 15 of the past 30 days.

Percentage* Reporting Poor Mental Health for At Least 15 of the Past 30 Days, Fall 2020



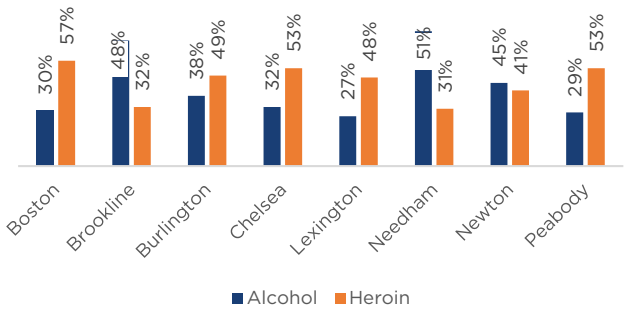
***Unweighted Percentages Displayed**

Source: MDPH COVID-19 Community Impact Survey, Fall 2020

Substance Use

Substance use continued to have major impacts on the BIDMC CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Interviewees, focus groups, and community listening session participants identified stigma as a barrier to treatment and reported a need for programs that address common co-occurring issues (e.g., mental health issues, homelessness).

Primary Substance of Use Among Those Admitted to DPH-funded Substance Use Treatment Centers, 2017



Source: Bureau of Substance Abuse Services, 2017

Boston and Chelsea

Interviewees, focus groups, and community listening session participants identified a need for more supportive services for individuals diagnosed with substance use disorders, including mental health services, transitional housing, support for employment and workforce development.

In both Boston and Chelsea, the most common substance of use among those admitted to DPH-funded treatment centers was heroin, followed by alcohol.

Other Municipalities in the BIDMC CBSA

In Brookline (48%), Needham (51%), and Newton (45%), the most common substance of use among those admitted to DPH-funded treatment centers was alcohol.

Chronic and Complex Conditions

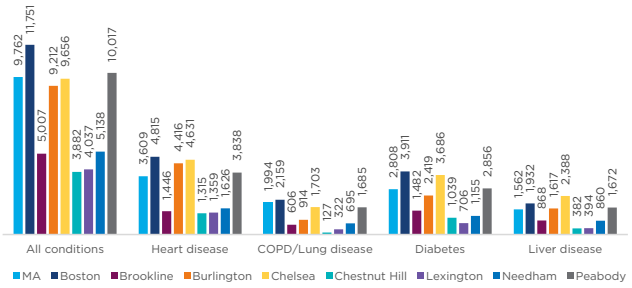
Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in the Commonwealth and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.[22]

Boston and Chelsea

The age-adjusted mortality rate was lower than the Commonwealth (654 per 100,000) overall in Boston (602), and higher than the Commonwealth in Chelsea (807).

Source: Massachusetts Death Report, 2019

Inpatient Discharge Rates (Per 100,000) For Chronic/Complex Conditions Among Those 45-64 Years of Age, 2019



Source: Center for Health Information and Analysis, 2019

Emergency room discharges for pediatric asthma were much higher than the Commonwealth (2,481 per 100,000) in Boston (4,645) and Chelsea (3,468).

Among those 45-64 years of age, emergency room discharges for diabetes were higher in both communities compared to the Commonwealth (4,109 per 100,000); in Boston, the rate was more than double (8,926).

Source: Center for Health Information and Analysis, 2019

Other Municipalities in the BIDMC CBSA

Inpatient rates among those 45-64 years of age for all conditions combined were similar or lower than the Commonwealth (9,762 per 100,000) in all communities except Peabody (10,017), where the rate was higher. Inpatient discharge rates for heart disease, diabetes, and liver disease were also higher than the Commonwealth in Peabody.

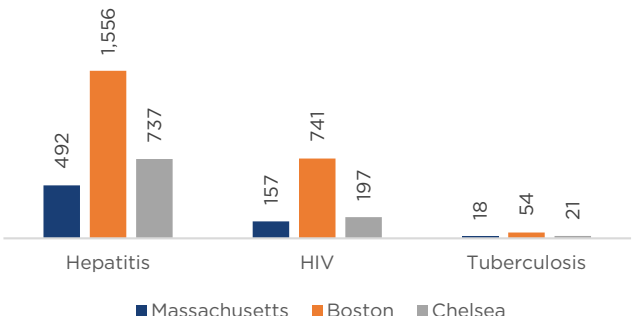
Communicable and Infectious Disease

Though great strides have been made to control the spread of communicable diseases in the U.S., they remain a major cause of illness, disability, and even death – as evidenced by the COVID-19 pandemic. Though not named as a major health concern by interviewees or participants of forums and focus groups, it is important to track data to prevent outbreaks and identify patterns in morbidity and mortality.

Boston and Chelsea

Data from the Center for Health Information and Analysis indicated that adults in Boston and Chelsea had higher inpatient discharge rates than the Commonwealth across several conditions, including Hepatitis, HIV, and Tuberculosis.

Inpatient Discharge Rates (per 100,000) Among Those 45-64 Years of Age, 2019

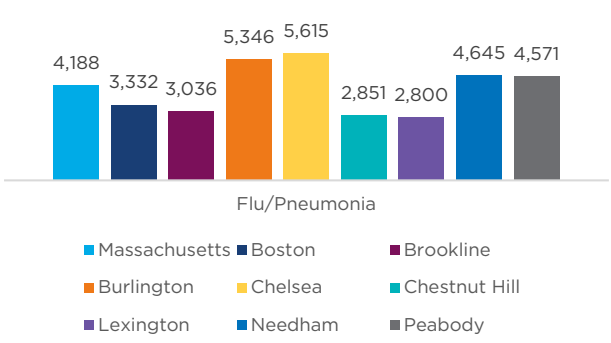


Source: Center for Health Information and Analysis, 2019

Other Municipalities in the BIDMC CBSA

The rate of inpatient discharges among those 65 years of age and older for flu/pneumonia was higher than the Commonwealth (4,188 per 100,000) in several CBSA communities: Burlington (5,346), Chelsea (5,615), Needham (4,645) and Peabody (4,571).

Inpatient Discharge Rates (per 100,000) Among Those 65 Years of Age and Older, 2019



Source: Center for Health Information and Analysis, 2019

COVID-19

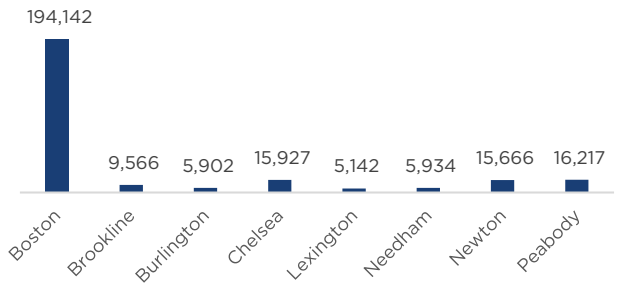
On March 11, 2020, the World Health Organization (WHO) declared the novel coronavirus a global pandemic. Society and systems continue to adapt and frequently change protocols and recommendations due to new research, procedures and policies. Interviewees, focus group and listening session participants, and survey respondents emphasized that COVID-19 is a priority concern that continues to directly impact nearly all facets of life, including economic stability, food security, mental health (stress, depression, isolation, anxiety), substance use (opioids, marijuana, alcohol), and one's ability to access health care and social services.

> "[The] uncertainty and anxiety that goes with COVID – it has impacted mental well being."
>
> -Boston CHNA-CHIP Collaborative interviewee

Boston and Chelsea

As discussed throughout this report, COVID-19 had significant impacts on all segments of the population, but there were disparities in risk, health outcomes, and after-effects for Black and Hispanic/Latino individuals. In Boston, 17% of adults reported persistent sadness during the COVID-19 pandemic, and this percentage was highest among Latinos (28%).
Source: BPHC BRFSS COVID-19 Health Equity Questionnaire

Total COVID-19 Case Counts as of June 30, 2022

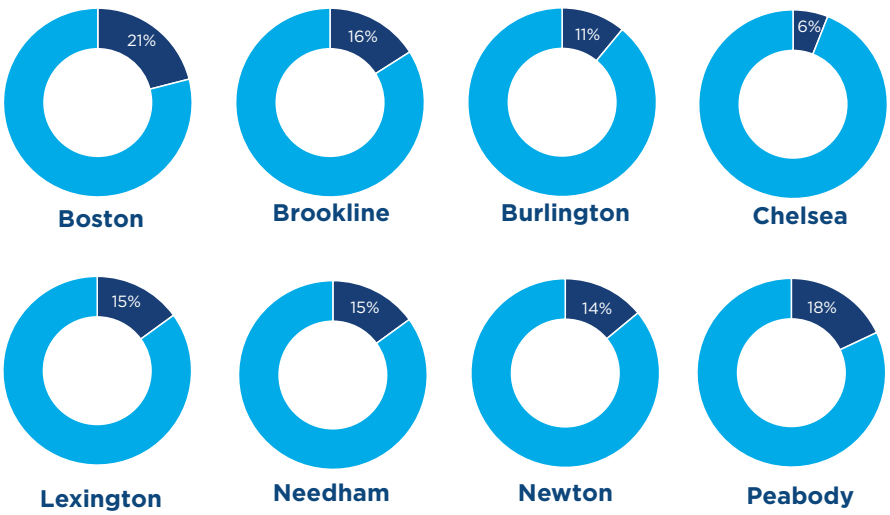


Source: Massachusetts COVID-19 Data Dashboard

Other Municipalities in the BIDMC CBSA

COVID-19 presented significant risks for older adults and those with underlying medical conditions because they faced a higher risk of complications from the virus. Several interviewees described how COVID-19 exacerbated poor health outcomes, inequities, and health system deficiencies. In all communities except for Chelsea, more than 10% of respondents to MDPH's COVID –19 Community Impact Survey reported that they were unable to get the medical care they needed during the pandemic.

Percentage* Who Have Not Gotten the Medical Care They Needed Since July 2020, As of Fall 2020



***Unweighted percentages displayed**

Source: MDPH COVID-19 Community Impact Survey, Fall 2020

Priorities

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its IS. By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that are faced with health-related disparities or are disproportionately impacted by systemic racism or other forms of discrimination. Accordingly, using an interactive, anonymous polling software, BIDMC's CBAC and community residents, through the community listening sessions, formally prioritized the community health issues and cohorts that they believed should be the focus of BIDMC's IS. This prioritization process helps to ensure that BIDMC maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes, and promote health equity.

The process of identifying BIDMC's community health issues and prioritized cohorts is also informed by a review and careful reflection on the Commonwealth's priorities set by the Massachusetts Department of Public Health's Determination of Need process and the Massachusetts Attorney General's Office.

Massachusetts Community Health Priorities

Massachusetts Attorney General's Office	Massachusetts Department of Public Health
• Chronic disease - cancer, heart disease, and diabetes • Housing stability/homelessness • Mental illness and mental health • Substance use disorder.	• Built environment • Social environment • Housing • Violence • Education • Employment.
Regulatory Requirement: Annual AGO report; CHNA and Implementation Strategy	*Regulatory Requirement: Determination of Need (DoN) Community-based Health Initiative (CHI)*

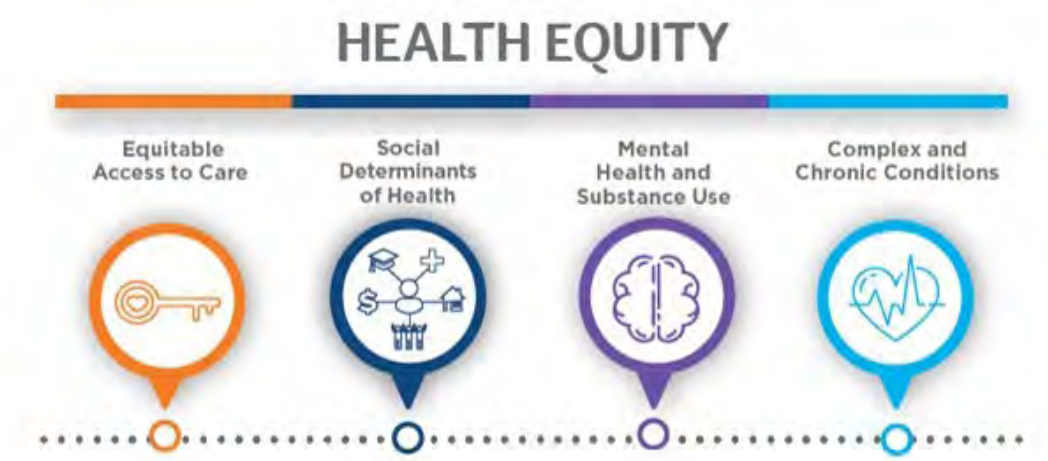
Community Health Priorities and Priority Cohorts

BIDMC is committed to promoting health, enhancing access, and delivering the best care for those in its CBSA. Over the next three years, the medical center will work with its community partners, with a focus on Chelsea and the Boston neighborhoods in its CBSA, to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, investments and resources will focus on improving the health status of the following priority cohorts and community health priority areas.

BIDMC Community Health Needs Assessment: Priority Cohorts

- **Youth**
- **Low-Resourced Populations**
- **LGBTQIA+**
- **Older Adults**
- **Racially, Ethnically and Linguistically Diverse Populations**
- **Families Affected by Violence and/or Incarceration**

BIDMC Community Health Needs Assessment: Priority Areas



Community Health Needs Not Prioritized by BIDMC

It is important to note that there are community health needs that were identified by BIDMC's assessment that were not prioritized for investment or included in BIDMC's IS. Specifically, addressing the digital divide (i.e., promoting equitable access to the internet) and supporting education across the lifespan were identified as community needs but were not included in BIDMC's IS. While these issues are important, BIDMC's CBAC and senior leadership team decided that these issues were outside of the medical center's sphere of influence and investments in other areas were both more feasible and likely to have greater impact. As a result, BIDMC recognized that other public and private organizations in its CBSA, Boston, and the Commonwealth were better positioned to focus on these issues. BIDMC remains open and willing to work with community residents, other hospitals, and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

Community Health Needs Addressed in BIDMC's IS

The issues that were identified in the BIDMC CHNA and are addressed in the hospital IS are housing issues, food insecurity, transportation, environmental justice/climate, economic insecurity, community safety, workforce development, small businesses, build capacity of healthcare workforce, navigation of healthcare system, linguistic access barriers, promotion/awareness of SDOH resources, diversify provider workforce, cost and insurance barriers, more peer-led services, addressing mistrust in healthcare, youth mental health, stress, depression, anxiety, isolation, impacts of violence & trauma, education (for communities, and for providers on how to best reach and treat them), stigma, racism (individual and systemic), culturally appropriate/competent health and community services, homophobia and transphobia, lack of education around diversity, equity, and inclusion (DEI), diversifying leadership, cross sector collaboration and responses, and linguistic access/barriers to community resources/services.

Implementation Strategy

BIDMC's current 2020-2022 IS was developed in 2019 and addressed the priority areas identified by the 2019 CHNA. The 2022 CHNA provides new guidance and invaluable insight on the characteristics of the BIDMC's CBSA population, as well as the social determinants of health, barriers to accessing care, and leading health issues, which informed and allowed BIDMC to develop its 2023-2025 IS.

Included below, organized by priority area, are the core elements of BIDMC's 2023-2025 IS. The IS is designed to address the underlying social determinants of health, barriers to accessing care, and promote health equity. The content addresses the leading community health priorities, including activities geared toward health education and wellness (primary prevention), identification, screening, referral (secondary prevention), and disease management and treatment (tertiary prevention)

Below is a brief discussion of the resources that BIDMC will invest to address the priorities identified by the CBAC and BIDMC's senior leadership team. Following the discussion of resources are summaries of each of the selected priority areas and a listing of the goals that were established for each priority area

Community Benefits Resources

BIDMC expends substantial resources on its community benefits program to achieve the goals and objectives in IS. These resources are expended, according to its current IS, through direct and in-kind investments in programs or services operated by BIDMC and/or its partners to improve the health of those living in its CBSA, particularly in the neighborhoods in Boston that have been prioritized and Chelsea. Additionally, BIDMC works on its own or with its partners to leverage funds through public or private grants and other funding sources. Finally, BIDMC supports residents in its CBSA by providing "charity" care to individuals who are low-resourced or those who are unable to pay for care and services. Moving forward, BIDMC will continue to commit resources through the same array of direct, in-kind, leveraged, or "charity" care expenditures to carry out its community benefits mission.

Recognizing that community benefits planning is ongoing and will change with continued community input, BIDMC's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies, and other issues that may arise, which may require a change in the IS or the strategies documented within it. BIDMC is committed to assessing information and updating the plan as needed.

The following are brief descriptions of each priority area, along with the goals established by BIDMC to respond to the CHNA findings and the prioritization and planning processes. Please refer to the Summary IS in Appendix E for more details.

Summary Implementation Strategy

EQUITABLE ACCESS TO CARE

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic and economic barriers.

Strategies to address the priority:

- Promote equitable care, health equity, health literacy, and cultural humility for patients across BIDMC and BILH's licensed and/or affiliated health centers, especially those who face cultural and linguistic barriers.
- Increase access to primary care and specialty care services, including OB/GYN and maternal child health services.
- Address the health-related social needs (HRSN) of patients in order to support access to care.
- Provide and promote career support services and career mobility programs to hospital employees.
- Promote access to health insurance, patient financial counselors, and needed medications for patients who are uninsured or underinsured.
- Advocate for and support policies and programs that address healthcare access.

- Support research aimed at providing more equitable care for patients and community members.
- Provide and support residents with transportation access, public safety, emergency care, public health and emergency preparedness.

SOCIAL DETERMINANTS OF HEALTH

Goal: Promote healthy neighborhoods by enhancing the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

Strategies to address the priority:

- Support evidence-based programs and strategies to reduce homelessness, reduce displacement, and increase home ownership by low-income individuals and families.
- Support evidence-based programs, strategies, and partnerships to increase employment and earnings and increase financial security.
- Promote thriving neighborhoods and enhance community cohesion and resilience.
- Increase mentorship, leadership, training, and employment opportunities for youth and young adults residing in the communities BIDMC serves.
- Advocate for and support policies and programs that address the social determinants of health.
- Conserve natural resources, reduce carbon emissions, and foster a culture of sustainability to create a healthy environment for residents.
- Build community awareness, advocate for policy change, and provide supportive care for victims of violence and trauma.
- Promote healthy eating and active living by increasing opportunities for physical activity and providing healthy food resources to patients and community residents.

MENTAL HEALTH AND SUBSTANCE USE

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use issues and conditions.

Strategies to address the priority:

- Support and implement evidence-based programs that increase access to high-quality and culturally and linguistically appropriate mental health and substance use services.
- Advocate for and support policies and programs that address mental health and substance use.
- Implement trauma-informed care (TIC) principles and other prevention strategies to improve care for all, especially those with a history of adversity.

COMPLEX AND CHRONIC CONDITIONS

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.

Strategies to address the priority:

- Provide preventive health information, services, and support for those at risk for complex and/or chronic conditions and support evidence-based chronic disease treatment and self-management programs.

Evaluation of Impact of 2020-2022 Implementation Strategy

As part of the assessment, BIDMC evaluated its current IS. This process allows the hospital to better understand the effectiveness of its community benefits programming and to identify which programs should or should not continue. Moving forward with the 2023-2025 IS, BIDMC and all BILH hospitals will review community benefit programs through an objective, consistent process using the BILH Program Evaluation and Assessment Tool. Created with Community Benefits staff across BILH hospitals, the tool scores each program using criteria focused on CHNA priority alignment, funding, impact, and equity to determine fit and inclusion in the IS.

Since 2020, some of the programs that would normally be conducted in-person were postponed or canceled due to the COVID-19 pandemic. When possible, programs are delivered virtually to ensure that the community is able to receive services to improve their health and wellness. The medical center dedicated significant time and resources to respond to COVID-19 needs. Below is a high-level overview of activities that BIDMC implemented to respond to COVID-19:

Testing:

- BIDMC deployed staff and worked with its licensed and/or affiliated community health centers and the hospital's Chelsea location to expand community testing access.
- Bowdoin Street Health Center (BSHC) and BIDHC-Chelsea reduced barriers to access by offering on-site interpretation, welcoming walk-ins, and not requiring a physician order.
- BIDMC supported the Community Care Alliance health centers by supporting testing, sharing BILH protocols, procedures, and guidelines in real-time, and providing clinical and other support (e.g., isolation housing for staff, food, low-literacy education materials, personal protective equipment (PPE), etc.) to the community.

Food Access:

- BIDMC partnered with community health centers and community-based organizations to supply and distribute both fresh and shelf-stable foods to families and individuals living in public housing in Boston.
- BSHC provided food boxes to residents in their community.
- BIDMC partnered with Charles River Community Health (CRCH) which provided households with food boxes and distributed free dairy items to patients during a mobile market.
- BIDMC provided low-cost access of rice and beans to About Fresh (for staple item boxes for Boston residents) and low-cost meal boxes to City of Chelsea residents via BIDMC's partnership with Sodexo.
- City of Chelsea residents were given masks, hand-sanitizer, Social Determinant of Health screening and connection to resources and gift cards to their local grocery store.

For the 2020-2022 IS process, BIDMC planned for a comprehensive strategy to address the prioritized health needs of the CBSA as outlined in the 2019 CHNA report. These strategies included grantmaking, in-kind support, partnerships, internal hospital programming, and charity care. Below is a summary of accomplishments and outcomes for a selection of community benefits programs for Fiscal Year (FY) 2020 and 2021. BIDMC will continue to monitor efforts through FY 2022 to determine its impact in improving the health of the community and inform the next IS. A more detailed evaluation is included in Appendix D.

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Priority Area	Summary of accomplishments and outcomes
Social Determinants of Health	• Addressed violence prevention through the Center for Violence Prevention and Recovery, Bowdoin Street Health Center's (BSHC) Neighborhood Trauma Team, BSHC's Youth Leadership Program, and BSHC's Village in Progress • Offered workforce development opportunities such as pipeline programs and youth summer jobs, through BIDMC's department of Education and Workforce Development • Funded seven (7) organizations to address housing affordability through BIDMC's Community-based Health Initiative • Funded 6 organizations to address jobs and financial security through BIDMC's Community-based Health Initiative • Funded 4 organizations in 3 Boston neighborhoods and the City of Chelsea to increase community cohesion through BIDMC's Community-based Health Initiative • Promoted environmental sustainability by decreasing greenhouse gas emissions and supporting local food and vendor spend • Funded the Dimock Center to address food insecurity among patients and community residents through a gift card-based program • Invested in a program to address food insecurity in Chelsea known as Chelsea Eats that provides residents with monthly debit cards • Invested in Chelsea Legal Aid Bureau to provide legal services and representation to City of Chelsea residents to address housing instability
Chronic/ Complex Conditions and Risk Factors	• Supported chronic disease management programs through partnerships with BIDMC's Community Care Alliance (CCA) Community Health Centers (CHC) • Addressed cancer disparities by providing cancer screenings to low-income individuals and CCA CHC patients • Collaborated with the Boston Breast Cancer Equity Coalition (BBCEC) to support the vision of eliminating the differences in breast cancer care and outcomes
Access to Care	• Supported CCA health centers to ensure linguistically and culturally appropriate access to care in the community • Increased access to quality medical services by screening and enrolling all eligible patients into entitlement programs (MassHealth and Health Safety Net) • Provided interpretation via in-person, telephone, and video services to patients who face cultural and linguistic barriers • Promoted greater health equity for LGBTQIA+ populations by implementing training for BIDMC staff on sexual orientation and gender identity (SOGI) • Provided ride shares/taxis, chair cars, and ambulances to BIDMC patients without transportation to medical appointments
Behavioral Health (Mental Health and Substance Use)	• Increased access to behavioral health services by providing integrated behavioral health consultations at Bowdoin Street Health Center's (BSHC) Primary Care Clinic • Provided 10 different support groups for issues ranging from cancer to pregnancy loss to create a network of support • Funded 7 organizations to address behavioral health through BIDMC's Community-based Health Initiative • Hired a second attending psychiatrist for the Division of Addiction Psychiatry to ensure BIDMC patients can be seen in the Link Clinic for Opioid Use Disorder care 5 days a week • BILH Behavioral Health conducted an extensive evaluation of the feasibility of implementing the IMPACT (Improving Mood, Promoting Access to Collaborative Treatment) model at BIDMC's licensed and/or affiliated community health centers. BILH Behavioral Health staff met with representatives from each community health center to review existing behavioral health programs. It was determined that BIDMC's licensed and/or affiliated community health centers already had integrated behavioral health care models that met IMPACT standards.

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Appendices

Appendix A: Community Engagement Summary

Appendix B: Data Book

Appendix C: Resource Inventory

Appendix D: Evaluation of 2020-2022 Implementation Strategy

Appendix E: 2023-2025 Implementation Strategy

Appendix A:
Community Engagement Summary

Interviews

- Interview Guide
- Interview Summary

Beth Israel Lahey Health Community Health Assessment

Interview Guide

Please complete this section for each interview:

Date:	Start Time:	End time:
Name of Interviewee:		
Name of Organization:	Affiliate Hospital:	
Facilitator Name:	Note-taker Name:	
Did all participants agree to audio recording?		
Did anything unusual occur during this interview? (Interruptions, etc.)		

Thank you for taking the time to speak with me today. Beth Israel Lahey Health (BILH) and [Hospital and any collaborators] are conducting a community health needs assessment and creating an implementation plan to address the prioritized needs identified. For the first time, all 10 hospitals in the BILH system are conducting this needs assessment together. Our hope is that we will create a plan at the individual hospital level as well as the system level that will span across the hospitals.

During this interview, we will be asking you about the strengths and challenges of the community you work in and the populations that you work with. We also want to know what BILH should focus on as we think about addressing some of the issues in the community. The data we collect during the assessment is analyzed, prioritized, and then used to create an Implementation Strategy. The Implementation Strategy outlines how the Hospital and System will address the identified priorities in partnership with community organizations. For example, if social isolation is identified as a priority, we may explore partnering with Councils on Aging on programs to engage older adults, and support policies and system changes around mental health supports.

Before we begin, I would like you to know that we will keep your individual contributions anonymous. That means no one outside of this interview will know exactly what you have said. When we report the results of this assessment, no one will be able to identify what you have said. We will be taking notes during the interview, but your name will not be associated with your responses in any way. Do you have any questions before we begin?

If you agree, we would like to record the interview for note taking purposes to ensure that we accurately capture your thoughts and obtain exact quotes to emphasize particular themes in our final report. Do you agree?"

[*<u>if interviewee does not agree to be recorded, do not record the interview]</u>

Question	Direct Answer	Additional Information
Community Characteristics, Strengths, Challenges		
What communities/populations do you mainly work with?		
• How would you describe the community (or population) served by your organization?		
• How have you seen the community/population change over the last several years?		
What do you consider to be the community's (or population's) strengths?		
How has COVID affected this community/population?		
What are some of its biggest concerns/issues in general? What challenges does this community/population face in their day-to-day lives?		
Health Priorities and Challenges		
What do you think are the most pressing health concerns in the community/among the population you work with? Why?		
• How do these health issues affect the populations you work with? [Probes: In what way? Can you provide some examples?]		
We understand that there are differences in health concerns, including inequalities for ethnic and		

racial minority groups **/** the impacts of racism. Thinking about your community, do you see any disparities where some groups are more impacted than others?		
• What contributes to these differences?		
What are the biggest challenges to addressing these health issues?		
What barriers to accessing resources/services exist in the community?		
Community-Based Work		
What are some of the biggest challenges your organization faces while conducting your work in the community, especially as you plan for the post-COVID period?		
Do you currently partner with any other organizations or institutions in your work?		
Suggested Improvements		
When you think about the community 3 years from now, what would you like to see?		
• What would need to happen in the short term?		
• What would need to happen in the long term?		
How can we tap into the community's/population's strengths to improve the health of the community?		

In what way can BILH and [Hospital] work toward this vision? What should be our focus to help improve the health of the community/population?		
Thank you so much for your time and sharing your opinions. Before we wrap up, is there anything you want to add that you did not get a chance to bring up earlier?		

I want to thank you again for your time. Once we finish conducting survey, focus groups and interviews, we will present the data back to the community to help determine what we should prioritize. We will keep you updated on our progress and would like to invite you to the community listening sessions where we will present all of the data. Can we add you to our contact list? After the listening sessions, we will then create an implementation plan to address the priorities. We want you to know that your feedback is valuable, and we greatly appreciate your assistance in this process.

BIDMC Community Health Needs Assessment 2021-2022
Key informant interview summary

BIDMC Interviewees

- Boston Public Health Commission: Dr. Bisola Ojikutu, Executive Director
- City of Brookline: Lynne Karsten, Director of Community Health
- Town of Lexington: Seven Municipal Leaders
- Town of Needham: Tim McDonald, Director of Health and Human Services
- Town of Burlington: Five Municipal Leaders
- City of Peabody: Five Municipal Leaders
- LISC Boston: Karen Kelleher, Executive Director
- City of Boston, Mayor's Office of Immigrant Advancement: Yusufi Vali, Director
- Black Ministerial Alliance/BMA TenPoint: Rev. David Wright, Esq., Executive Director
- Health Leads Boston: Sarah Primeau, Director of Programs and Jennifer Valenzuela, Chief People and Equity Officer
- City of Boston: Natalia Urtubey, Director of Small Business
- Massachusetts Affordable Housing Association: Symone Crawford, Executive Director
- Metropolitan Area Planning Council: Sharon Ron, Senior Planner
- Fenway Health: David Todisco, Director of Behavioral Health
- Boston Center for Independent Living: Bill Henning, Executive Director
- Greater Boston PFLAG: René Rives, Program Manager
- Tech Goes Home: Marvin Venay, Chief Advocacy Officer
- South Cove Community Health Center: Eugene Welch, CEO and Executive Director
- Boston Women's Fund: Netanja Craig-Oquendo, Executive Director

New England Baptist Hospital (NEBH) Interviewees – themes shared with BIDMC

- City of Boston: Kenzie Bok, City Councilor
- Boston Police Department: Nora Baston, Deputy Superintendent
- Tobin Community Center: John Jackson, Administrative Coordinator
- Mission Hill Neighborhood Housing Services: Pat Flaherty, Executive Director
- Roxbury Tenants of Harvard: Karen Gately, Executive Director
- Roxbury Tenants of Harvard: Sophiya Detch, Sophia Deng, Pauline Lin - residents
- Mission Main: Miss Willie Pearl, Tenants Task Force
- Alice Taylor Housing: Matilda Drayton, Tenants Task Force
- Mission Hill Main Streets: Ellen Walker, Executive Director
- Mission Hill Link: Maggie Cohn, Board Member
- Maria Sanchez House: Elimercy Martinez, Senior Property Manager
- City of Boston, Age Strong Commission: Emily Shea, Commissioner
- Mission Hill Health Movement: Mary Anne Nelson, Executive Director
- Sociedad Latina: Alexandra Oliver-Davila, Executive Director
- ABCD, Park Hill Fenway: Jenny Sugilio, Director
- Nancy Ahmadifar, Community Resident
- Madison Park High School: Brian Miller, Special Education Teacher

Note: BIDMC's Community Health Needs Assessment also incorporated findings from the key informant interviews and focus groups conducted as part of the Boston Community Health Needs Assessment.

BIDMC Community Health Needs Assessment 2021-2022
Key informant interview summary

Community Health Improvement Plan Collaborative (Boston CHNA-CHIP Collaborative) and the North Suffolk Integrated Community Health Needs Assessment (iCHNA).

Community characteristics

- Organizations willing to come together to address challenges – was especially apparent over the course of the pandemic
- Diverse neighborhoods and residents, in terms of race/ethnicity, household composition (mix of students, older adults, families)
- NEBH - sense of unity in Mission Hill neighborhood; Strong network of community organizations and history of activism

Social Determinants of Health

- Overarching – COVID exposed existing SDOH issues that inhibit access to care (transportation, internet access)
    - Especially complicating things for older adults, individuals best served in language other than English
- Housing is significant concern – gentrification, overdevelopment, students rental market displacing residents
- Economic insecurity and job loss – exacerbated by COVID
- Food insecurity is a concern, though more about cost of healthy foods rather than lack of options
- NEBH - Transportation is a perennial concern for many; especially older adults. Mission Hill can be difficult to navigate for anyone with a mobility issue

Mental health

- Significant prevalence of depression, anxiety, and stress across all segments of the population
    - Isolation a critical concern for older adults - especially those who are frail, homebound, disabled
    - Particular concerns for youth mental health – youth are stressed; lives upended by COVID. Increase in behavioral health issues among young people have ripple effect on teachers and school providers/staff
- Mental health impacts of those affected by community violence, trauma
- Need more diversity among mental health providers
    - "*We need more mental health services that are not rooted in the white dominant culture, but that are rooted in people's cultural experiences."- BIDMC key informant*

Access to care

- Access to care issues exacerbated by pandemic – long wait times or providers not taking on new patients
- Difficult for people to navigate complexities of healthcare system, including ghealth insurance. Even more difficult for certain segments of the population (e.g., those best served in a language other than English, older adults, individuals with no family or caregiver)
- Cost/insurance barriers

BIDMC Community Health Needs Assessment 2021-2022
Key informant interview summary

- Language barriers – need for more diverse providers that speak languages other than English
- Immigration status can be a barrier to care – mistrust; fear or having to disclose immigration status
- Move to telehealth good for some; harder for those without tech resources or tech knowledge
- NEBH - Mission Hill - difficult to secure transportation to get to and from appointments

Chronic/complex conditions

- NEBH
    - People expressed concern about respiratory illness – feeling that these issues may be exacerbated in neighborhood because of high percentage of residents in public housing, proximity to traffic
    - Mobility issues for older adults
    - Need diabetes and cancer management programs
    - Cognitive decline/memory issues a concern for older adults

Diversity, equity, inclusion

- BIDMC
    - Significant recognition of how trauma, stress, anxiety of racism and discrimination affect health
    - Concerns around discrimination against LGBTQ+ population, especially transphobia
    - Racial and ethnic disparities in health care access exposed by COVID
    - Need more targeted support/care for non-English speakers and undocumented individuals
    - *"The inequities that have been impacting Black and Brown people are still happening today, over 18 months later. We have corporations and government and city officials talking about these disparities in health access, in food, in access to affordable and safe places to live" – BIDMC key informant*
- NEBH - Homebound elders facing significant issues accessing needed care and services

Assets/Resources

- BIDMC – political will; resource sharing and collaboration among community organizations; diversity; resilience; educational opportunities; diversity
- NEBH – community cohesion; network of organizations serving the needs of older adults; resource sharing and collaboration; diverse and non-judgmental; many long term community members; green space; friendliness; libraries

Focus Groups

- Focus Group Guide
- Focus Group Summary Notes

Opening Script (10 Minutes)

Thank you for participating in this discussion on health in your community. I'm going to review some information about the purpose and ground rules for the discussion, then we'll begin.

We want to hear your thoughts about things that impact health in your community. The information we collect will be used by Beth Israel Lahey Health to create a report about community health. We will share the results with the community in the winter and identify ways that we can work together to improve health and wellbeing. The is used to put together a plan that outlines how the Hospital and System will address the identified priorities in partnership with community organizations.

We want everyone to have the chance to share their experiences. Please allow those speaking to finish before sharing your own comments. To keep the conversation moving, I may steer the group to specific topics. I may try to involve people who are not speaking up as much to share their opinions, especially if one or more people seem to be dominating the conversation. If I do this, it's to make sure everyone is included. We are here to ask questions, to listen, and to make sure you all have the chance to share your thoughts.

We will keep your identity and what you share private. We would like you all to agree as a group to keep today's talk confidential as well. We will be taking notes during the focus group, but your names will not be linked with your responses. When we report the results of this assessment, no one will be able to know what you have said. We hope you'll feel free to speak openly and honestly.

With your permission, we would like to audio record the focus group to help ensure that we took accurate notes. No one besides the project staff would have access to these recordings, and we would destroy them after the report is written. Does everyone agree with the audio recording?

If all participants agree, you can record the Zoom. If one or more person does not agree or are hesitant, do not record the focus group.

Does anyone have any questions before we begin?

Section One: Community Perceptions

1. To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy?

2. What are some of the things that make it hard for you, and your community members, to be healthy?

3. Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly?

   If yes, move on to Section 2.

   If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation)

   Let's talk more deeply about these concepts.

Section Two: Key Factors

In this section, ask participants to go more in depth about the factors they brought up in the previous section. For example, if they brought up the lack of affordable healthy foods, ask "are healthy foods available to some people, if so who? And why do you think they are not available to everyone?"

For each issue they identified:

- Are these (things that keep you healthy) available to everyone or just a few groups of people?

- Why do you think they (things that make it hard to be healthy) exist? / Why is this a challenge?

Section Three: Ideas and Recommendations

4. **Ideas:** Thinking about the issues we discussed today, what ideas do you have for ways hospitals can work with other groups or services to address these challenges?
    1. Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of?

5. **Priorities**: What do you think should be the top 3 issues that Hospitals and community organizations should focus on to make your community healthier?

Date: 11/16/21	Start Time: 6 pm	End time: 7 pm
Group Name and Location: BIDMC-YMCA Youth Advisors, Egleston Square (Virtual)		

Where are you from and what do you love about your neighborhood?

- Brighton: Everything is within walking distance
- Dorchester: Everything is within walking distance – nail salon, grocery store
- Roxbury: Food
- Back Bay: Safe and Beautiful

- What keeps you healthy?
  - Healthy relationships (friendships)
  - Parks
  - Schools
  - Sports
  - Transportation
- What does healthy mean to you?
  - Being Safe
  - Happiness
  - Mindset
  - Working out
  - Good appetite
  - Good environment
  - Good connections
  - Build up
- What takes away from being healthy
  - Drugs
  - Social media
  - Stress
  - Anxiety
  - Negative people
  - Not enough access to educational resources
  - Being negative
  - Financial stability
  - Not enough communication
  - Depression
  - Health conditions: Lupus (disease)
  - Long lasting friendships and relationships
  - Not working together
  - Abuse
  - Mindset (on both sides)
  - Behavior
  - Perception
- Are things that make you healthy available to everyone or certain groups? Who are the people that don't have access?
  - Minorities

        - Mostly black
        - A mix of both
- Where does stress, depression, or anxiety coming from?
    - School
        - Pressure to be good
        - Pressure to not disappoint people
        - Homework
        - Teachers – caring too much or not caring enough
        -
    - Household stuff
    - Social media
        - Negative information
            - Trying to be like other people even though that's not who they are
            - Peer pressure or feeling like the need to be someone different
        - Rumors
        - Social media brings people down
        - Social media can be a positive
            - Yes but it depends on what its affecting
            - It can help with communication
- Do you see a lot of drugs? Where do you see it?
    - School
    - Neighborhood
    - School – most kids either do it and brag about it or do it and say nothing
    - 14, 15, 16 year old's
    - 15 - 18
    - Younger kids
- Why do you think teens are using drugs
    - Stress
    - Some do it because their friends or family do it
    - Some do it too look cool and say they do it
    - To fit in
    - Coping mechanism
    - It bring them some happiness
- How can we address the things that make you not happy?
    - Healthy students
        - More healthy relationships
            - Friends, family, people you are dating
    - Healthy food
    - Good connection – people socializing more
        - Face to face
- What could adults in your life do to help (youth y workers, family, teachers)
    - Stop expecting too much
    - They want to flourish but they egg on too much it because to much pressure
    - Communicate with them

- What about health care providers? What can hospitals do?
    - Take care of us
        - Mentally
            - Support
        - Great role models
        - Listening
        - Spaces to safely express themselves
    - Try to understand our point of view and understand where they are coming from

Date: 11/17/21	Start Time: 6 pm	End time: 7 pm
Group Name and Location: Families impacted by violence and/or incarceration (Virtual)		

Section One: Community Perceptions

1. To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy?

2. What are some of the things that make it hard for you, and your community members, to be healthy?
    - People who are not vaccinated and don't wear masks - nobody comes out to speak to people in Spanish. Concerned people will get sick. **There is no communication about the risk** that is out there - especially the kids say they won't need one, won't get sick. Laundromats.
    - Food - spoiled or close to being spoiled. **Access to healthy safe food** - many nods.
    - Forget to **take care of ourselves** as parents & grandparents. Especially through the pandemic. When it comes to ourselves we don't take care of ourselves.
    - Masks - work at a Food Bank and they keep forgetting to put them on or pull up; get offended. At the end of the night I'm exhausted. Little things to feel healthy safe and wise and get up the next day to do it again.
    - **Food, Environment, & Health** - yoga and meditation are healing. 100 autoimmune diseases. 75% women carry. How it connects to stress, loss, diet, environment - chemical exposures (low & high such as diesel). They have an impact on all our major organs. My sisters and brothers aren't doing well even though it seems like we're doing well.
    - Mothers and families struggling with **mental health, loss of loved ones, not knowing where to go with our health**.
    - **Trauma - everyday trauma. Youth and mental health** - when our kids walk to school they walk by memorials of youth that got killed, candles, liquor bottles… There were nurses and counselors when I went to school, but they [don't have that] they have to go in and just focus on work. There are drug dealers and they are afraid. They didn't talk to the kids about COVID when they returned to school. They have PTSD. They just throw my family in without dealing with the issues including what happened during the pandemic. It is trauma, after trauma - including for me. When I drive the bus. Other communities the kids have access to such great schools, sports fields [it's hard to see].
    - A lot of littering.
    - Grandson was shot at Dudley St. Park. Was in the hospital and they moved him. Has depression. Called the nurse and said he couldn't breathe. Told him not to bother her and she didn't take the time to assess his stress and pain. He discharged himself - left the hospital and now his brain is affected. Was a good

kid-not in trouble. Mother is stressed caring for siblings. **DIdn't give him a wheelchair or pain medicine. In pain crying in the bed. How do we get help?**

- **COVID and how to make our way through it - The Health Dept has not given accurate information** out there adequately. A lot of people are not wearing the mask - since were told didn't have to because had the vaccination. They think it is the unvaccinated. People are dying who were vaccinated. Where is the reality shared that whether you are vaccinated or not you are at risk? May even be higher risk because you don't realize it is in your body and you are spreading it. She is treated as an outsider having had COVID. It's upside down what is happening in the community and the health system is playing a huge role.
- Survivor - both sons shot and killed. **What's helped has been being engaged with different organizations that talked about harm**, going to prison and doing restorative justice. Being able to deal with my mental health. All those who have lost children to violence it is a horrible impact. This time of year can be a challenge (birthdays, gloom, dates when were died). Having sisters to reach out to. Always somebody being shot in the community.
- **Policy reform needed on cutting off benefits:** People are so mean - can't say anything to anyone. Still depressed, have PTSD. Social Security just said that they will stop my disability. Had said could work, but now can't work 20 hours and get paid. If I didn't work, I'd lose my sanity thinking about my son who was killed. Try to talk to the youth. Kids aren't raised to respect people.

3. Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly?
    1. Mental health
    2. COVID
    3. Environment (stress of chemical exposures/trash)
    4. Support & services - especially peer support and **Improved healthcare quality - equity**

Ideas and Recommendations

1. **Ideas:** Thinking about the issues we discussed today, what ideas do you have for ways hospitals can work with other groups or services to address these challenges?
    a. Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of?
        - Social/emotional programming. Adolescent growth development (9-20 years old) need to deal with autonomy, peer pressure… and need to deal with external anxieties. Need to understand the central nervous system and learn ways to control anxiety, self-regulation, calm the body down. Sports, arts, yoga - intentional programs to understand their bodies early in life and manage social emotional anxieties.

- Having a healthy routine - exercise, food, financial resources is a challenge. Have Multiple Sclerosis - hard to keep the routine going but it is so important.
- Trauma and mental health - what are the resources, including for grief from sudden loss. Those that have slipped into a deep depression. Need more information and resources. Goddaughter lost her 25 yr old daughter. Has separated herself from everyone including her mother. Drinking. Wouldn't answer her phone. What can support her?
- Need to support the children - services as parents are consumed by their own grief. Teachers don't understand that they are acting up because they have internalized the trauma. Send them to another school Others agree. Pockets of communities - Have small community centers for after school - all was taken away due to COVID. Mental illness, trauma, violence, all started. We did a good job as parents but they did not give us any resources on COVID, teaching them about how to protect themselves. Runs a community center. They need to bring those resources back in the community. Mother whose son just got life in prison - couldn't find help. Community centers are overstressed. We need to find a way to come together to build our community up together again. We are strong, brilliant, and have what it takes but they aren't giving us what we need.
- We have the resources within us - peer groups set up so the community can be the resource. Hands on people don't get the resources, the organizations that come in and take the credit and don't do anything they get the resources. My house was traumatized by COVID - nobody has asked us what we need now that almost lost her. Couldn't visit her mother in hospital because she had COVID
- Need to have a first aid kit at home, teach CPR. We can do this but need to bring these resources together - even if on a group zoom. It just takes ten of us to come together and save our children. We fed 2,700 families today. I have mental health issues you just don't see. I was hungry too. Beautiful people. Missing the hugs and facial sharing of feelings.
- Mental health and a drug addiction and then COVID changed everything. Lost father to COVID - he had mental health [challenges] & drug addiction, drinking. Was always at methadone mile - a person needs to want it. Children are having to take care of their parents [parent].
- Peer work - BayCOVE key facilitator, will bring down. In our Own Voice Presenter for NAMI Mass. MS peer to peer. Sister Circle Peer Consultant.

2. **Priorities**: What do you think should be the top 3 issues that Hospitals and community organizations should focus on to make your community healthier?

- Supported in how to support the community - community-driven, peer supports.

- Don’t need money: I need all my AA sisters to give me that back rub, shake me, tell me everything will be alright. Support group for ourselves. We can’t connect after the Zoom. Get the laughter back. Play cards & play bingo. After traumas nobody helped.
- DO NEED MONEY - Most impoverished community in the city. Our work has been taken away due to COVID. It’s huge - The inequities. Should be focused on.
- We are Better Together - supporting criminally-involved children and those who have lost their children to violence.
- [Co-facilitator] will bring it to people who will bring results.
- Need economic & social systems to get out of the way. Health. Mom’s peer group. It wasn’t the doctors.

Actionable Recommendations Developed by JSI Based on Themes

- Alert all healthcare staff that poor treatment of people of color has been reported leading to poor health outcomes and provide opportunities for training on equity and culturally-responsive care.
- Disseminate updated COVID-19 guidance for every healthcare visit (such as masks and social distance are vital as rates of highly contagious and dangerous strains are increasing across all age groups).
- Offer post-discharge supports to ensure strong individual and family recovery from serious COVID-19 cases.
- Work with school health to offer updated COVID-19 messaging tailored to youth. Include resources to help youth with the impact of COVID-19 on their lives. Recommend that schools look for signs of COVID-related impacts and trauma/PTSD in youth (discourage suspensions in lieu of restorative justice and mental and social supports). Assist schools in creating content for COVID-19 lessons.
- Establish/strengthen peer support networks & programs within neighborhoods. Engage residents in activities for their communities that they can feel positive about contributing towards.
- Increase mental health offerings & awareness of mental health/SUD services.

Date: 11/15/21	Start Time: 5 pm	End time: 6 pm
Group Name and Location: Cantonese-speaking immigrants (Virtual)		

Section One: Community Perceptions

1. To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy?
    - Environment and hygiene
        - e.g. Do more promotion about public health, for example encouraging people to take the booster shot. So if more people take the booster shot, people around them will feel safer.
    - Public Safety
        - Good public safety will allow me to feel assured/have a peace of mind.
    - Housing
        - Giving individual families their own housing will allow them to feel healthy. A lot of people in Chinatown currently share an apartment with several families because rent is too expensive.
    - Community Centers
        - Having the Golden Age Center improved my health a lot. The center would let us know/send us current updates and information, and they host different activities for seniors. This really helps with seniors' health.
    - Good job opportunities
        - Jobs with good wages that protect the working class.
2. What are some of the things that make it hard for you, and your community members, to be healthy?
    - Housing
        - As mentioned above, some families in Chinatown share the same apartment with other families. This hurts their mental health.
        - Some students also share an apartment together with 7-8 other people.
    - Homeless population
        - There are too many homeless people around the Boston area. There seems to be even more homeless people after COVID. The homeless people makes me scared.
    - Marijuana
        - Too many people are smoking weed. We can always smell weed at home and on the streets. The smell of weed makes me feel unwell and unsafe.
    - Trash around Chinatown
        - The trash cans are always overflowing, no one cleans them up. The smell is awful, and people start littering everywhere.
    - Food prices went up
        - Wages are similar, but food prices have gone up a lot.
    - Air and noise pollution

        - Chinatown is situated right next to the 90 and 93 highway. The air pollution is really bad and it negatively affects our health. It is also really noisy. People don't want to open their windows.

3. Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly?

- Housing
- Public Safety
- Hygiene

Let's talk more deeply about these concepts.

Section Two: Key Factors

In this section, ask participants to go more in depth about the factors they brought up in the previous section. For example, if they brought up the lack of affordable healthy foods, ask "are healthy foods available to some people, if so who? And why do you think they are not available to everyone?"

For each issue they identified:

- Housing
    - Only available to a few groups of people – the wait time is very long
    - A lot of affordable housing and elderly housing have been built in the 70s and 80s, but they didn't build much after that. But now they build a lot of luxury housing. Now there are a lot of vacant luxury housing but regular people can't live there. However ones who need housing need to line up for a very long time. If luxury apartments are going to be built, the government should also build more affordable housing so more people can be benefitted.
    - This will affect people's mental health
    - People will feel very mentally stressed. They will always worry whether they have money to pay next month's rent.
    - It is hard for families with young kids to rent apartments. Landlords will reject you.
    - There are more and more high-rises. There are more exhaust and CO2 coming from these buildings and it negatively impacts others. The air quality has deteriorated a lot in the last decade.

- Hygiene
    - Only available to a few groups of people – the streets in Chinatown are very dirty

- This is because the people are not disciplined, and there is lack of regulating/ penalty. They should legislate to prevent people from throwing trash everywhere.
- Once the streets are dirty, there will be a lot of cockroaches and rats. A lot of them near Oxford Street.
- People who go through the trash would tear open the plastic bags and don't tie it back properly.
- They should issue penalties for littering or tying trash bags improperly.
- There aren't enough trashcans and recycle bins in Chinatown. We need more promotion/education in both English and Chinese, and more trash cans.

- Public Safety
  - A lot of people are smoking weed and this negatively affects our public safety.
  - The smell of weed makes me feel unsafe and uncomfortable.
  - If the aroma is too strong, it makes me dizzy and my throat hurt/cough.
  - Once I smell it I want to vomit.
  - The government should designate specific spots for people to smoke weed

Section Three: Ideas and Recommendations

1. **Ideas:** Thinking about the issues we discussed today, what ideas do you have for ways hospitals can work with other groups or services to address these challenges?
   a. Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of?

- Provide more bilingual (Chinese and English) information and updates, news, workshops, events to promote different programs and social events/happenings.
- Hospitals should provide a direct Chinese phone line, instead of requesting Cantonese/ Mandarin at the answering machine and wait for multiple transfers.
- Hospitals can purchase vacant properties and rent it out to patients who need affordable housing.
- Hospitals can provide bilingual social workers to help people fill out forms etc.

2. **Priorities**: What do you think should be the top 3 issues that Hospitals and community organizations should focus on to make your community healthier?

- Bilingual community updates/promotion
- Make more health-related visual and graphic flyers for the community
- Host more talks and lectures

Beth Israel Lahey Health Community Health Assessment
Focus Group Interviews

Date: 12/6/21	Start Time: 6p	End time: 7:30p
Group Name and Location: Spanish speaking essential workers (virtual)		

Section 1: Community Perceptions	

What does it mean to be healthy?	- Physical activity (1)1
	- Eating well, eating vegetables (1)1.1
	  - Eating nutritious foods
	  - Sometimes our culture focuses too much on carbs
	  - Sugar is so low when i arrived to this country. Adaptation to the new foods is a challenge.
	- As immigrants, we are learning everything new.
	- Sleeping well (1)
	- Healthy environment
	- Many people don't even consider seeking healthcare because it's too expensive
	  - The health system is complicated
	  - Work takes priority
	- Not knowing what to do when you get to know country
	- Important to focus on social, emotional and physical health
	- Mental health, focus on our mind (1.1.1)
	  - I am from Brazil and a lot of people died at home. A lot of people lost their jobs.
	-

Healthy: To get started, let's talk about what affects our health. When you think about your community, what are some of the things that help you to be healthy?	

<table>
<tr>
<td>Unhealthy: What are some of the things that make it hard for you to be healthy?</td>
<td>

Work hours

Everything is expensive, giving back to our family in our native countries

After corona, people are more worried about
Stress and our daily routine

Affects our physical and mental health

We need to check how we’re doing internally

There is no available appointments, calls are always being transferred, healthcare system is very difficult

It’s hard to take care of ourselves. We need to focus not only on our physical but also mentally
Nutritious foods are incredibly EXPENSIVE 1.1.1
Dental health is incredibly expensive

</td>
</tr>
<tr>
<td>Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly?

If yes, move on to Section 2.

If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation)

Let’s talk more deeply about these concepts.</td>
<td>Top Factors
1. Access to nutritious food
2. Invest in the healthcare system
3. Mental health services in the community</td>
</tr>
<tr>
<td colspan="2"><u>Section 2: Exploring Key Factors</u>
In this section, ask participants to go more in depth about the factors they brought up in the previous section.</td>
</tr>
</table>

Are these **(things that keep you healthy)** available to everyone or just a few groups of people?	● Not Asked
Why do you think they **(things that make it hard to be healthy)** exist? - Why is this a challenge?	● Not Asked
What are some examples of how these challenges impact someone's health?	● Not Asked
Section 3: Ideas and Priorities	
Ideas: - Thinking about what we have all talked about, what ideas do you have for ways hospitals can work with other groups or services to address the challenges of your community at this time? - Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of?	● Nutrition: Different ways of receiving nutrition other than food ○ Different approaches to medicine ○ The food in the US has a lot more toxins than in Brazil ○ Supplements could be helpful ● Mental health: ○ Many adolescents have suffered much with their mental health and emotional health, youth don't really understand what's going on in themselves ○ Finding providers is incredibly difficult, especially for young people. ○ We have to create new programs within the community to help people ■ Support groups, affinity groups, teaching people how to relax your mind, meditation, health practices ■ "more mental health program in schools." ○ Different approaches other than medication for depression ■ Addressing stressors holistically ● "mis hijos y yo emos pasado momentos dificil me gusto lo que Laura dijo de que ayuden mas con los seguros abeses no nos ponen atenciopor ser emigrante" - "My children and I have had difficult times. I liked what [name] said about helping more with insurance because they don't pay attention to us because we are immigrants."

	● Prioritizing and trying to balance our life ● Mobile clinics in the community
Priorities: - What do you think should be the top 3 issues service providers should focus on to make your community healthier?	● Nutritious foods ● Mental health ● Teaching people how to balance ○ Teaching health techniques
Section 4: Final Remarks & Closing	
Are there other factors that influence your health that we have not discussed tonight that you feel are important?	

Notes from 11/8/21: BIDMC Essential Workers Focus Group

Date: 11/8/21	Start Time: 6 pm	End time: 7 pm
Group Name and Location: Spanish Speaking Essential Workers (Virtual)		

Section One: Community Perceptions

1. To get started, let's talk about what affects our health. What does it mean to be healthy? ¿Qué significa para usted ser saludable?

Notes:

- Health means feeling good
- To have good mental health
    - People get sick because they think too much in their situations (e.g. immigration, economics, family)
    - This causes stress, depression, anxiety
- Emotional health
- Eating healthy
- Health is foundational for our humanity
    - With our health we can enjoy life
    - 1. Eating healthy
    - 2. Following medical advice
- Good health means having opportunities to rest, to have good environments in work, with family, with myself

2. When you think about your community, what are some of the things that help you to be healthy?

Notes:

- Information is not disseminated to the community, especially for non-English speakers
    - Put information in the supermarket with different languages
- Legal services
- Churches with programming food pantry and English classes and health insurance
    - Outreach workers
- This is a country of opportunities

3. What are some of the things that make it hard for you to be healthy?

Notes:

- Immigrant health
    - Difficulties with education and healthcare
    - Food insecurity
    - Because an immigrant, you don't get paid a living wage

- There is a real fear for immigrants
    - Do not like to share information
- Food insecurity
    - People don't need to share their information
- Not knowing the English language
- Lack of mental health providers who speak Spanish
    - The waitlist is very long
    - Interpreters can be challenging
        - Spanish Dialects depending on region and country

4. Based on what you have shared, it sounds like [name 3-4 of the top factors that we brought up] impact health for you. Did I capture that correctly?

   If yes, move on to Section 2. If no, ask for clarification on key factors and come to consensus on the 3-4 factors that will shape the rest of the conversation)

   Let's talk more deeply about these concepts.

Notes:

1. Bilingual providers
2. Mental health
3. Health education campaign/dissemination of information

Section Two: Key Factors

In this section, ask participants to go more in depth about the factors they brought up in the previous section. For example, if they brought up the lack of affordable healthy foods, ask "are healthy foods available to some people, if so who? And why do you think they are not available to everyone?"

Probing questions to deepen conversation of factors brought up in section one:

Notes:

1. Bilingual providers
    a. Interpretation services are not the answer
    b. Encouraging people in the community to get an education, provide scholarships and grants for community members to become providers
2. Mental health
    a. More providers
    b. Accessible medication
    c. Programs and support groups
3. Health social campaigns

a. Education campaigns addressing substance use, youth programs
b. Encourage municipalities to launch education campaign systematically

Section Three: Ideas and Recommendations

1. **Ideas:** Thinking about what we have all talked about, what ideas do you have for ways hospitals can work with other groups or services to address those challenges of your community at this time?

Notes:

- More Bilingual providers
- Mental health
  - More providers
  - Accessible and affordable medication
  - Programs and support groups
- Health social campaigns
  - Education campaigns addressing substance use, youth programs
  - Encourage municipalities to launch education campaign systematically
  - Disseminate information via mail, bus station
- We need more organizations that will address fear for the newcomer.
  - We need places that will educate immigrants.
  - Programs for youth immigrants

a. Based on what you shared in the beginning about the things that keep you healthy, what of the things you mentioned would you like to see more of?

Notes:

CBOs, churches, legal services that provide outreach and education to newcomers in the United States. Free English classes.

2. **Priorities**: What do you think should be the top 3 issues service providers should focus on to make your community healthier?

Notes:

1. Bilingual providers

2. Mental health
3. Health education campaigns

Community Listening Sessions

- Presentation from Facilitation Training for community partners
- Facilitation guide for listening sessions
- Listening Session presentation
- Priority vote results and notes from January 19, 2022 listening session
- Priority vote results and notes from January 27, 2022 listening session

John Snow Research and Training Institute, Inc.

Beth Israel Lahey Health

FACILITATION TRAINING

Best Practices on Inclusive Facilitation

October 07, 2021
Virtual Room

AGENDA

- What is facilitation?
- Inclusive facilitation
- Creating inclusive space
- Characteristics of a good facilitator
- Let's practice!

WHAT IS FACILITATION?

Facilitation is a dance, an artform.

INCLUSIVE FACILITATION

inclusive means including everyone

Provide space and identify ways participants can engage at the start of the meeting

Depending on the size of the group, ask participants to share their name, pronouns, and in one word describe how they're feeling today.

Dedicate time for personal reflection

Normalize silence. It’s okay if folks are quiet, don’t interpret as non-participation. Encourage people to take the time to reflect on the information presented to them.

Establish community agreements

Create common ground. This helps with addressing power dynamics that may be present in the space.

CREATING INCLUSIVE SPACE

move at the speed of trust

Identify ways to make people feel welcomed

We shouldn't assume everyone feels comfortable enabling their video. Make this an option as opposed to a request.

Design for different learning and processing styles

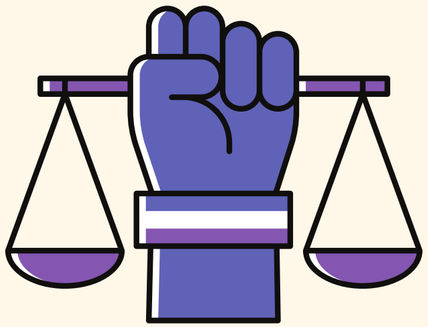
Support visual learners with a slideshow or other images. Real-time note-taking or tools that allow people to see how information is being processed and documented help each person stay engaged in the conversation.

Consider accessibility

Some folks may join through the dial in number, so consider walking through your agenda as if you were only on the phone. Consider language interpretation and closed captioning services.

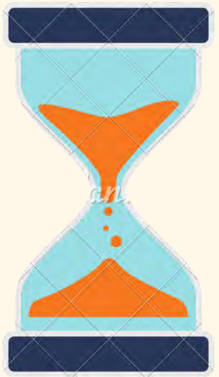
CHARACTERISTICS OF A GOOD FACILITATOR

Impartial



Active listener

Authentic



Patient

Enthusiastic

LET'S CONSIDER THE FOLLOWING

1

A participant seems to dominate the conversation.

2

A participant has a lot of experience in the topic but is too shy to share them in a group setting.

3

A participant is talking about something not related to the topic of discussion.

THANK YOU FOR YOUR PARTICIPATION!

Beth Israel Lahey Health

Feel free to send in any questions to **corina_pinto@jsi.com.**

BILH Community Listening Session: Breakout Discussion Guide

Session name, date, time: [Filled in by notetaker]
Community Facilitator: [Filled in by notetaker]
Notetaker: [Filled in by notetaker]

Mentimeter link:
Jamboard link:

Ground rules and introductions (5 minutes)

Facilitator: "Thank you for joining the Community Listening Session today. We will be in this small breakout group for approximately 45 minutes. Let's start with brief introductions and some ground rules for our time together. I will call on each of you. If you're comfortable, please share your name, your community, and one word to describe how you're feeling today. If you don't want to share, just say pass. I'll start. I'm ____ from ____ and today I'm feeling _____."
(Facilitator calls on each participant)

"Thanks for sharing. I'd like to start with some ground rules to be sure we get the most out of our discussion today:

- Make space and take space. We ask that you try to speak and listen in equal measure
- Be open to learning about experiences that don't match with your own
- What is said here stays here; what is learned here leaves here. [Notetaker's name] will be taking notes during our conversation today, but will not be marking down who says what. None of the information you share will be linked back to you specifically.

Are there other ground rules people would like to add for our discussion today?"

Question 1 (5 minutes)

Facilitator: What is your reaction to data and preliminary priorities we saw today?

- *Probe: Did anything from the presentation surprise you, or did this confirm what you already know?*
- *Probe: What stood out to you the most?*

Notes:

Question 2 (15 minutes)

Part 1: 10 minutes

Notetaker: *List preliminary priority areas from presentation in the Zoom chat.*

Facilitator: "We're going to move on to Question 2. Our notetaker has listed the preliminary priority areas from the presentation in our Zoom chat. Looking at this list – are there any priority areas that you think are missing?"

Notes on missing priority areas:

[After 5 minutes, the Meeting Host will pop into your Breakout Room to collect any additional priority areas.]

Part 2: 5 minutes

[Meeting host will send Broadcast message when it's time to move on to Part 2]

Facilitator: "We want to know what priority areas are most important to you. Right now, our notetaker is going to put a link into the Zoom chat. (Notetaker copies & pastes Mentimeter link: <<**https://www.menti.com/yqztahwt4c**>>. When you see that link, please click on it.

"Within this poll, we want you to choose the 4 priority areas that are most concerning to you. The order in which you choose is not important. We'll give you a few minutes to make your selections.

"If you're unable to access the poll, go ahead and put your top 4 priority areas into the chat, or you can say them out loud and we can cast your vote for you.

After a few minutes, the poll results will be screen shared to our group."

[Meeting Host will pop in to your room to ensure all votes have been cast. After confirmation, Meeting Host will broadcast poll results to all Breakout Groups]

Facilitator: "It looks like (A, B, C, D) are the top four priority areas for this session. Our Notetaker will type these into the Chat box so we can reference them during our next activity."

Question 3 (25 minutes)

Facilitator: "Next, we'd like to discuss how issues within these priority areas might be addressed. We know that no single entity can address all of these priorities, and that it usually takes many organizations and individuals working together. For each priority area we want to know about existing resources and assets – what's already working? – and gaps and barriers – what is most needed to be able to successfully address these issues."

Let's start with [Priority Area 1].

- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?

Let's move on to [Priority Area 2].

- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?

Let's move on to [Priority Area 3].

- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?

Let's move on to [Priority Area 4].

- What resources and assets exist to address this issue?
- What are the gaps and barriers within this priority area?"

Notetakers will be taking notes within Jamboard.

[Meeting Host will send a broadcast message when there are 2 minutes left in the Breakout Session]

Wrap Up (1 minute)

Facilitator: "I want to thank you all for sharing your experiences, perspectives, and knowledge. In a minute we're going to be moved back into the Main Zoom room to hear about some of the things discussed in the groups today, and to talk about the next steps in the Needs Assessment process. Is there anything else people would like to share before we're moved out of the breakout room?"

Notes:

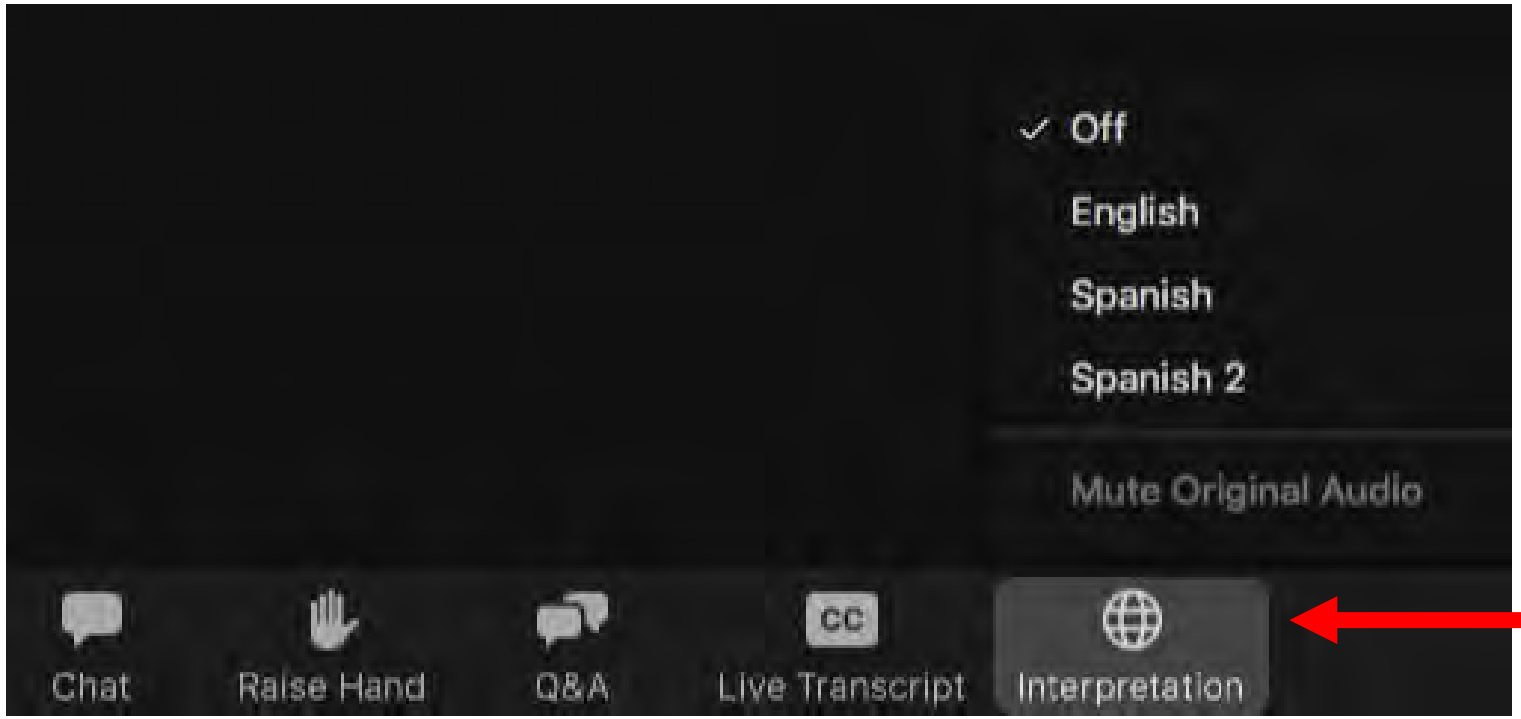
BETH ISRAEL DEACONESS MEDICAL CENTER

January 19, 2022
January 27, 2022

Beth Israel Lahey Health

Artist Performance – Ms. Cookie Gamble

粵語翻譯



選擇您的音頻頻道

Beth Israel Deaconess Medical Center (BIDMC) Community Listening Session

Beth Israel Lahey Health

Beth Israel Deaconess Medical Center

Boston CHNA-CHIP Collaborative

North Suffolk Public Health Collaborative

an initiative of the communities of Revere, Chelsea and Winthrop

BIDMC Community Listening Session

Agenda

Time	Activity	Speaker/Facilitator
6:00-6:05	Artist Performance	Ms. Cookie Gamble
6:05-6:10	Opening Remarks	JSI
6:10-6:20	Overview of assessment purpose, process, and guiding principles	Robert Torres
6:20-6:30	Presentation of preliminary themes and data findings	JSI
6:30-7:25	Breakout Groups	Community Facilitators
7:25-7:30	Wrap up: Closing statements and next steps	Robert Torres

Assessment Purpose and Process

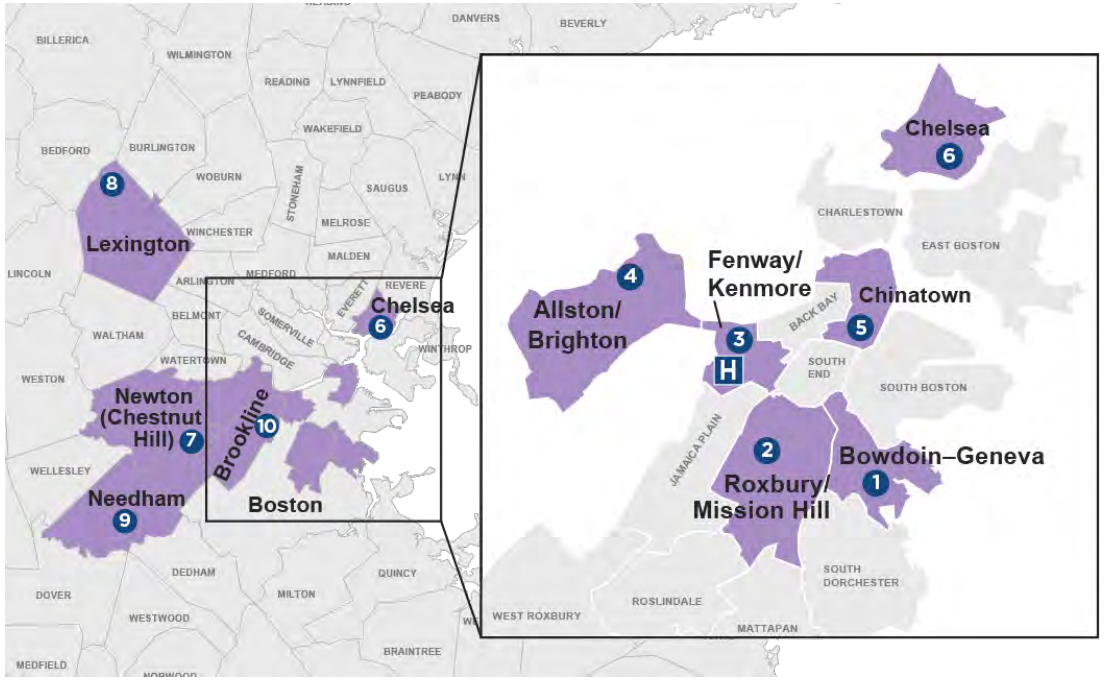
Assessment Purpose and Process

Purpose

A **Community Health Needs Assessment** identifies key health needs and issues through data collection and analysis.

An **Implementation Strategy** is a plan to address public health problems collaboratively with municipalities, organizations, and residents.

All non-profit hospitals are required to conduct a Community Health Needs Assessment (CHNA) and develop an Implementation Strategy (IS) every 3 years



Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Community Benefits Service Area

- H Beth Israel Deaconess Medical Center
- 1 Bowdoin Street Health Center
- 2 The Dimock Center
- 3 Fenway Health
- 4 Charles River Community Health
- 5 South Cove Community Health Center
- 6 Beth Israel Deaconess Healthcare-Chelsea
- 7 Beth Israel Deaconess Healthcare-Chestnut Hill
- 8 Beth Israel Deaconess Healthcare-Lexington
- 9 BIDMC Cancer Center
- 10 BIDMC Pain Center

Assessment Purpose and Process

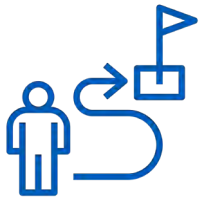
FY22 CHNA and Implementation Strategy Guiding Principles

Equity: Work toward the systemic, fair and just treatment of all people; engage cohorts most impacted by COVID-19

Collaboration: Leverage resources to achieve greater impact by working with community residents and organizations

Engagement: Intentionally outreach to and interact with hardly reached populations; including but not limited to people impacted by trauma, people with disabilities, communities most impacted by inequities, and others

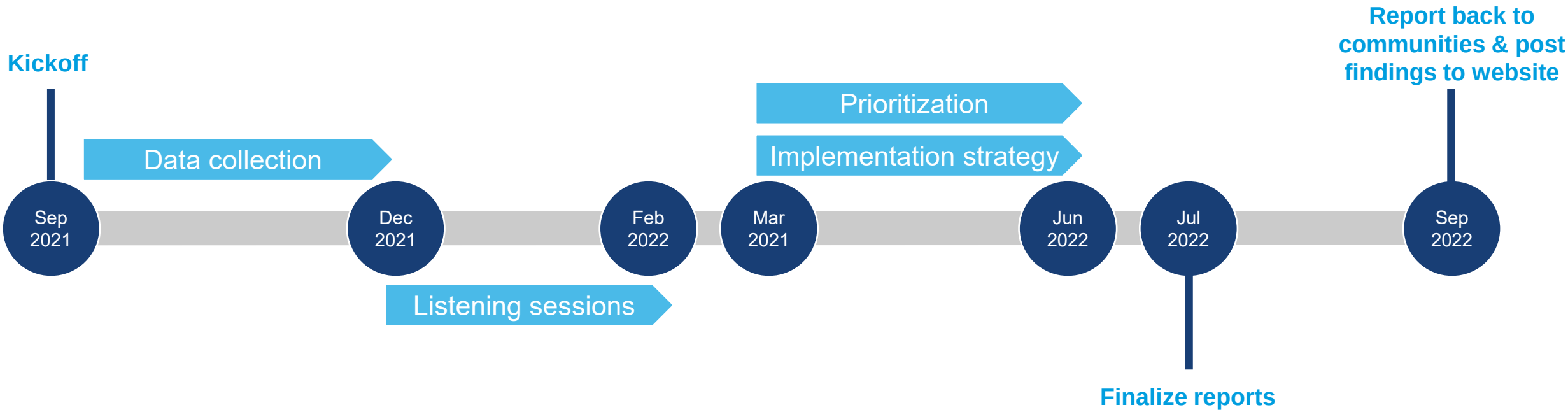
Capacity Building: Build community cohesion and capacity by co-leading Community Listening sessions and training community residents on facilitation



Intentionality: Be deliberate in our engagement and our request and use of data and information; be purposeful and work collaboratively to identify and leverage resources for maximum benefit

Assessment Purpose and Process

FY22 CHNA and Implementation Strategy Process

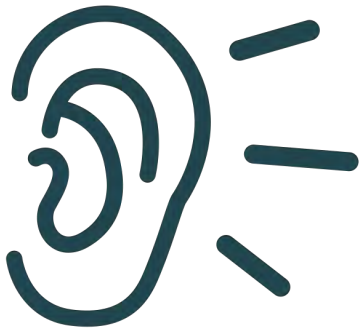


Assessment Purpose and Process

Meeting goals

Goals:

- Conduct listening sessions that are ***interactive, inclusive, participatory and reflective of the populations*** served by BIDMC
- Present data for prioritization
- Identify opportunities for ***community-driven/led solutions and collaboration***



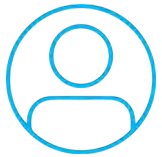
We want to hear from you.
Please speak up, raise your hand, or use the chat when we get to Breakout Sessions

Key Themes & Data Findings

CHNA Progress
Activities to date

Collection of secondary data, e.g.:

- ✓ Massachusetts Department of Public Health
- ✓ Center for Health Information and Analytics (CHIA)
- ✓ County Health Rankings
- ✓ Behavioral Risk Factor Surveillance Survey
- ✓ Youth Risk Behavior Survey
- ✓ US Census Bureau



16 **Key Informant Interviews**

5 **Focus Groups**

-Spanish-speaking essential workers (2 groups)

-Individuals impacted by violence and/or incarceration

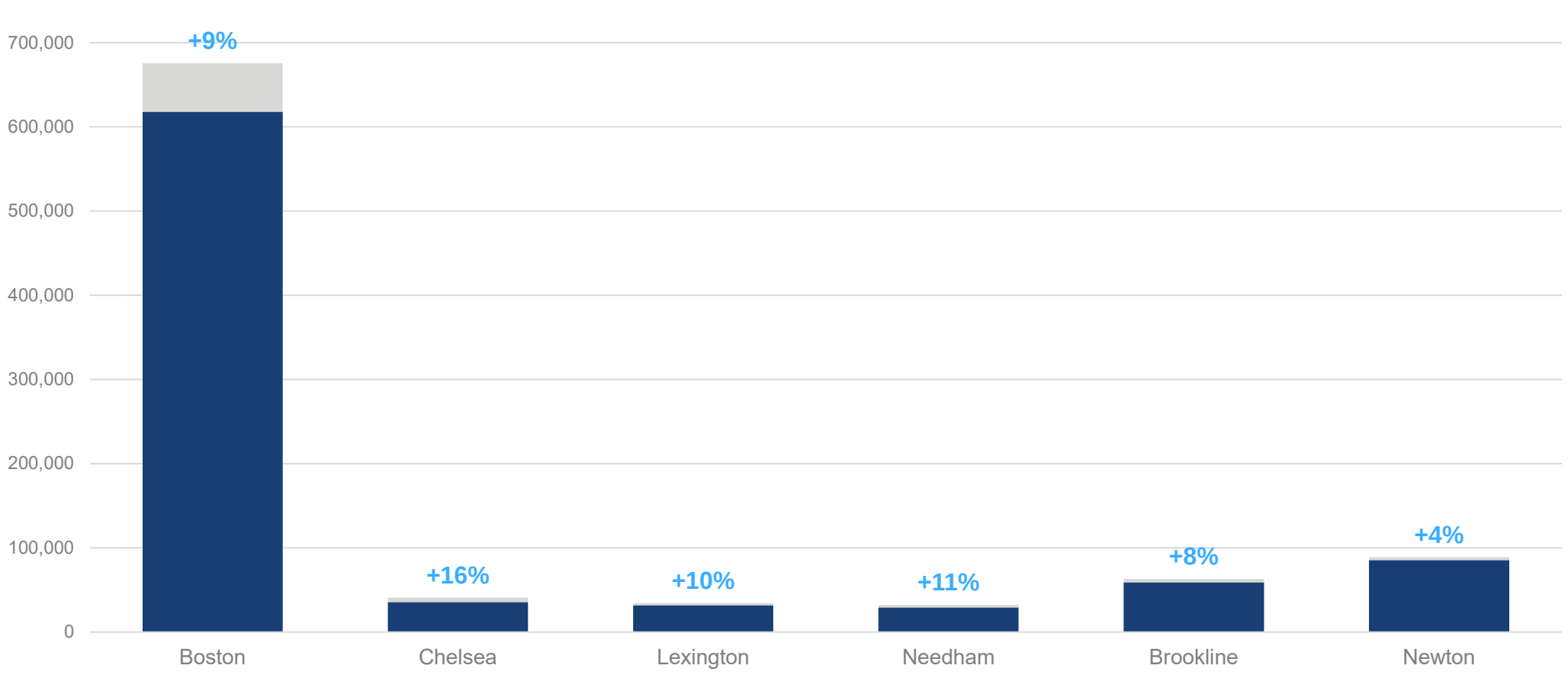
-Immigrants who speak Cantonese

-Youth Advisors

46 **Youth Survey Respondents**
(still open)

CHNA Progress

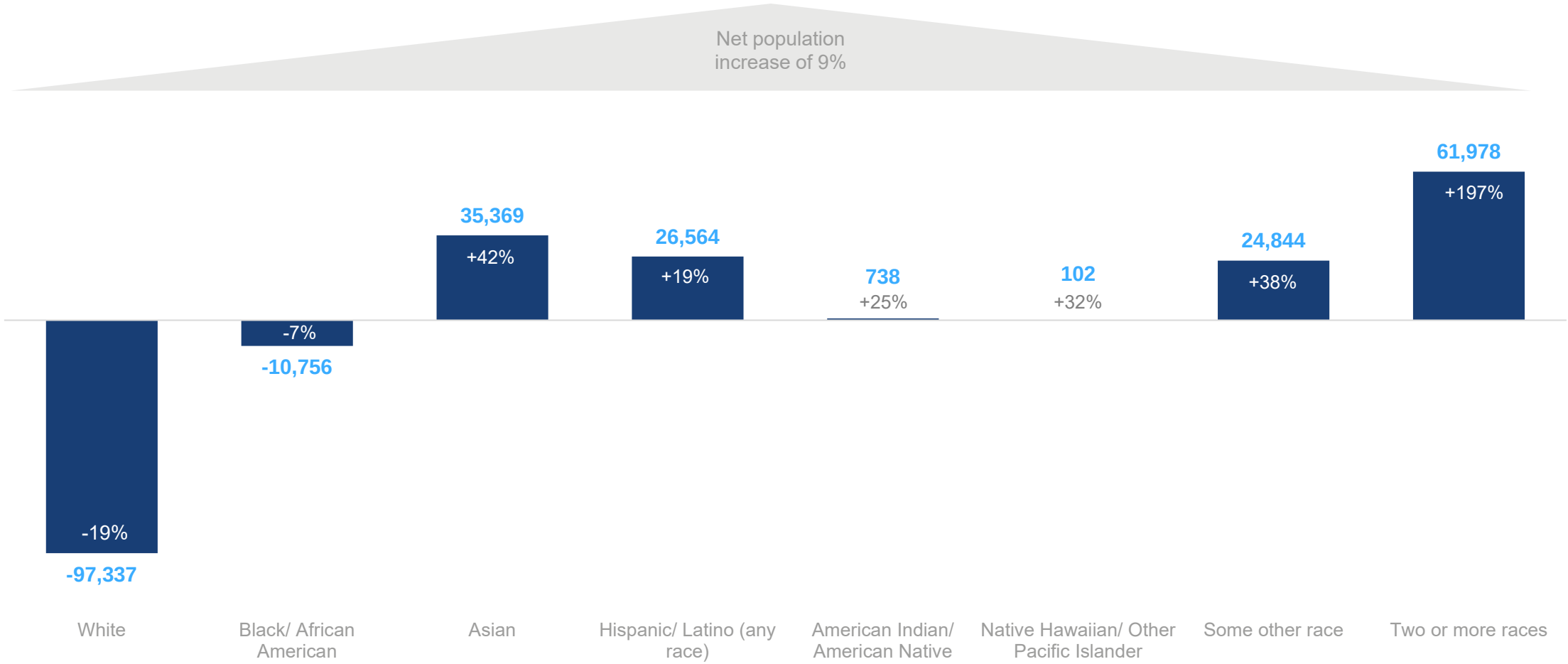
Population Change in Community Benefits Service Area 2010-2020



Total population increase of 9% (78,098)

CHNA Progress

Race/Ethnicity Population Change in Community Benefits Service Area, 2010-2020



CHNA Progress
Service Area Strengths

FROM INTERVIEWS & FOCUS GROUPS:

- Many organizations working together to address challenges
- Resilient
- Diverse residents
- Easy to walk
- Diverse restaurants and food choices

CHNA Progress
Key themes

- **Social determinants of health**
- **Diversity, equity, inclusion**
- **Mental health**
- **Access to care and services**

CHNA Progress
Key Themes: Social Determinants of Health

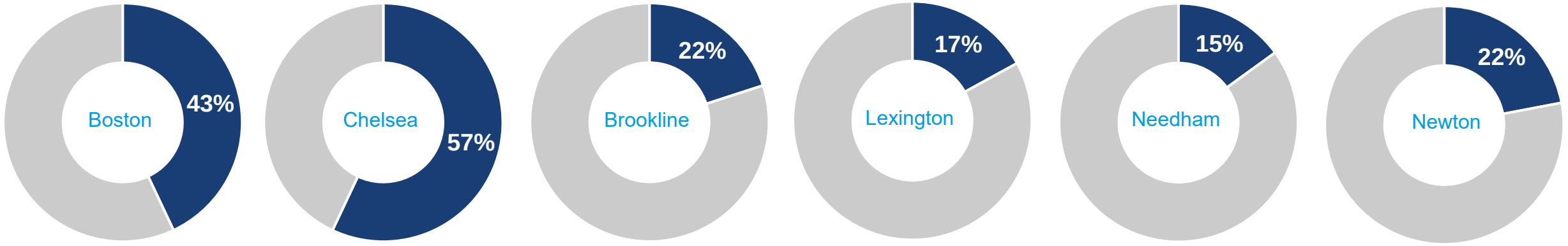
Primary concerns:

- Lack of affordable housing; gentrification and impacts of development in Boston neighborhoods
- Economic insecurity/high cost of living
- Food insecurity
- COVID exposed existing SDOH issues that inhibit access to care (e.g., transportation, internet access), especially for people of color and non-English speakers

When asked what they'd like to improve in their community, **59%** of BILH Community Health Survey respondents reported

"more affordable housing"
(#1 response)

Percentage* worried about paying for one or more type of expense/bills in the coming weeks (Fall 2020)



**Unweighted percentages displayed*

Data source: COVID-19 Community Impact Survey, MDPH

CHNA Progress
Key Themes: Diversity, Equity, and Inclusion

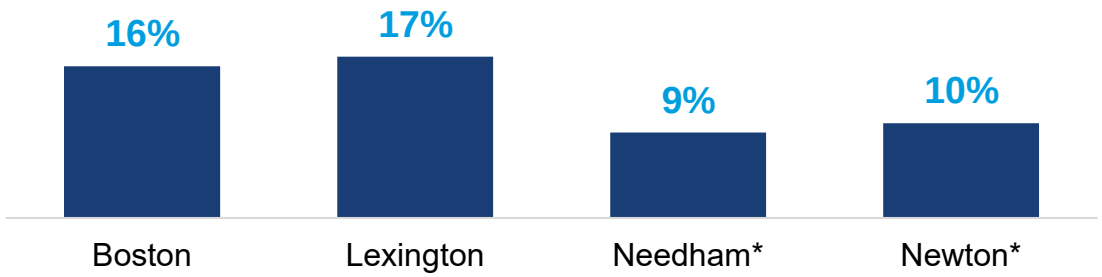
- Significant recognition of how trauma, stress, anxiety of racism and discrimination affects health
- Concerns about discrimination against LGBTQ+ population, especially transphobia
- Racial and ethnic disparities in health care access and outcomes were further exposed by COVID-19
- Need more recognition and supportive services for non-English speakers and undocumented populations

""The inequities that have been impacting Black and Brown people are still happening today, over 18 months later. We have corporations and government and city officials talking about these disparities in health access, in food, in access to affordable and safe places to live."– ***Key informant***

CHNA Progress
Key Themes: Mental Health (Youth)

- Significant prevalence of stress, anxiety, behavioral issues
  - Exacerbated by COVID
  - 45% of Youth Survey Respondents report School and Grades to be a cause of stress and anxiety
- Increase in behavioral health issues resulted in difficulties for educators and in-school providers/staff

Percentage High Schoolers Reporting Suicidal Ideation



*Data from Youth Risk Behavior Survey 2019 (*2018); data in other communities available in previous years*

"Mental health – especially for young adults – needs more attention."

– Focus group participant

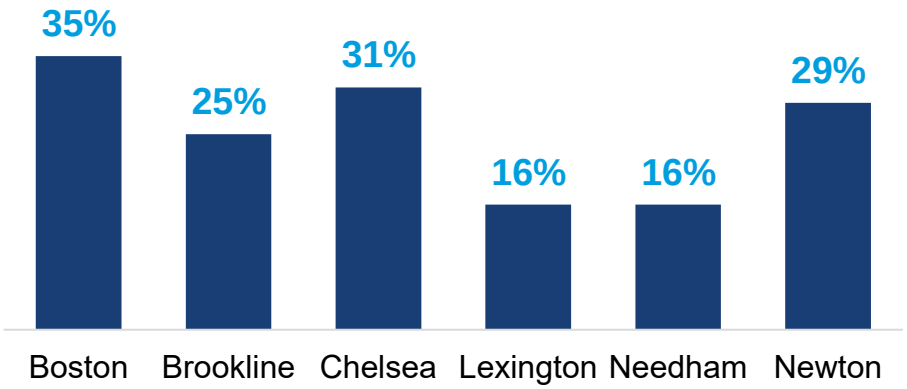
CHNA Progress
Key Themes: Mental Health (Adult)

Mental health issues exacerbated by COVID – anxiety, stress, depression, isolation

"We need more mental health services that are not rooted in the white dominant culture, but that are rooted in people's cultural experiences."

-Key informant

Percentage* with 15 or more poor mental health days in the past month (Fall 2020)



**Unweighted percentages displayed*

Data source: COVID-19 Community Impact Survey, MDPH

CHNA Progress

Key Themes: Access to Care

Difficulty accessing care because of:

- Long wait times
- Lack of providers
- Cost/insurance
- Language barriers
- Immigration status

Difficulties navigating and understanding healthcare system and insurance

"People don't have the best healthcare plans, if they have access to health care at all. If you have high deductibles, you're less likely to go to the hospital or to go to the Doctor to get help. If you've got no healthcare, then that puts you in the emergency ward."

– Focus group participant

Breakout Sessions

Reconvene

Wrap-up
BIDMC Community Benefits

Robert Torres, MPA
Director, Community Benefits
Boston Region
Beth Israel Lahey Health
robert.torres@bilh.org

Community Benefits Information on website:
https://www.bidmc.org/about-bidmc/helping-our-community

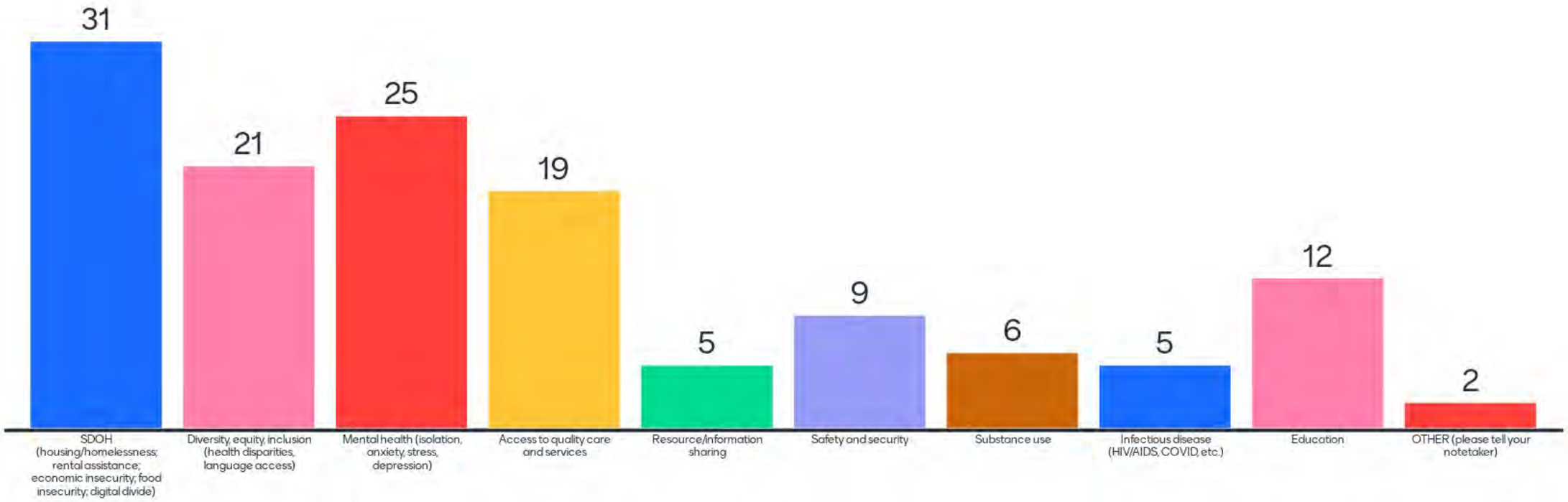
Community Benefits Annual Meeting on June 28th

Thank you!

Choose your top 4 priority areas.

Mentimeter

Polling results from January 19, 2022 session



Notes from 1/19/2022 session

Priority Area 1: SDOH

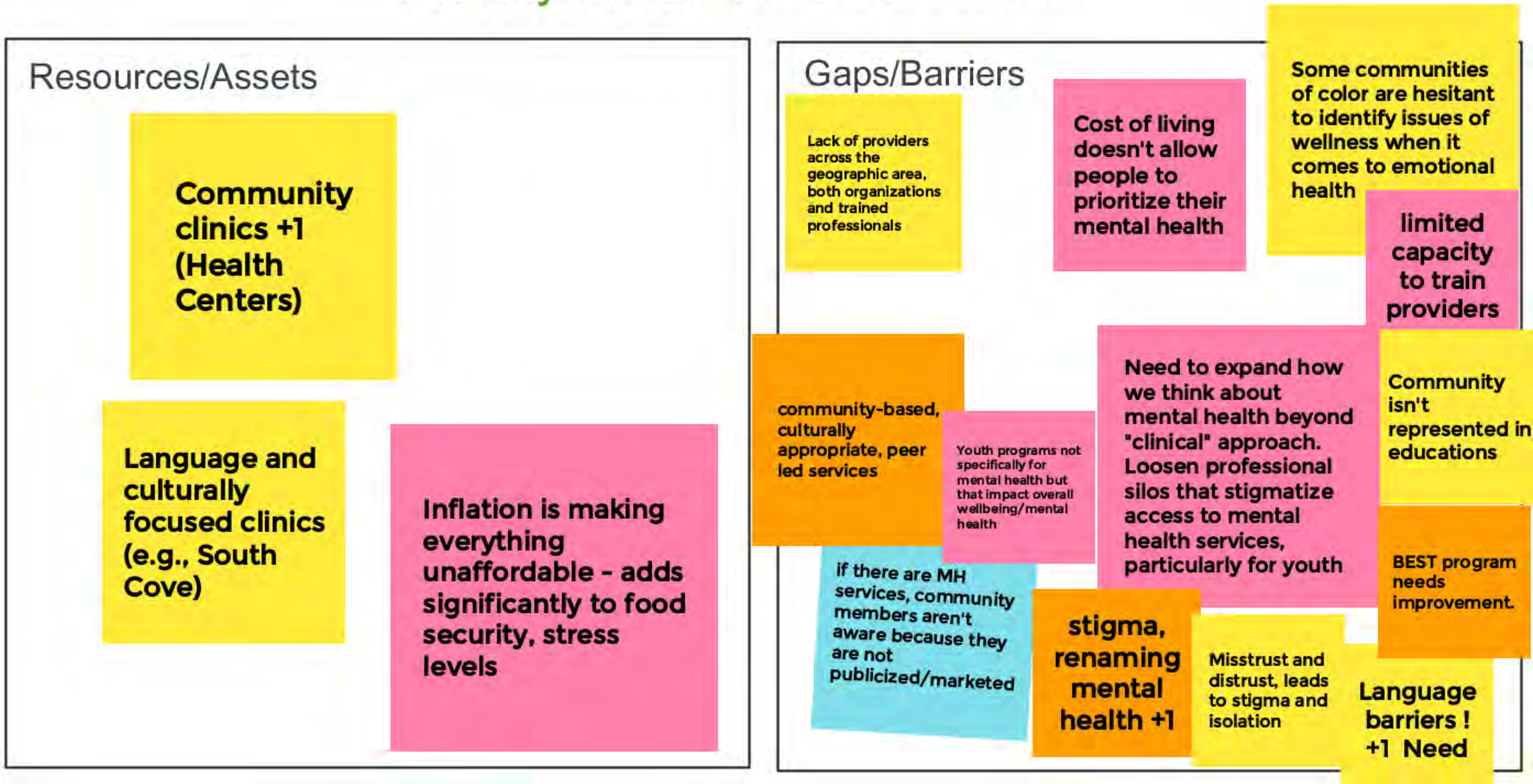
Resources/Assets

- giving money directly. people with tight budgets know how to manage money (an overlooked strength)
- Support for Housing development agencies and community development organizations
- salvation army, chelsea collaborative are helpful
- Housing supported by Hospitals are currently empty - are these able to be repurposed and rented out at more affordable prices?
- Policy change to streamline access to programs
- Need to continue to level the playing field when it comes to applications for assistance and mortgages and assistant
- Housing Navigators

Gaps/Barriers

- Education always seems to be lost. Without preparation, we won't be able to do anything. Children of color don't have access to enriched learning
- Housing: Never enough housing +1
- Reduce bureaucracy, presumptive eligibility
- we need collaboration from all organizations providing services, they should provide services in one place
- Zip code is a determinant, continued existence of redlining
- inaccessibility of existing resources (unable to speak to someone, waiting times)
- Need resources share programs and help people to navigate
- Need for affordable and accessible housing +1
- Need for price control on food
- Gentrification
- developers have the power. build power among affordable housing advocates
- affordable housing!!
- It's difficult to find an agency that provides rental assistance that provides services equitably, not just certain groups

Priority Area 2: Mental Health



Priority Area 3: Diversity, Equity, Inclusion

Resources/Assets

Very limited resources

Need to build capacity to address racism

Gaps/Barriers

Language access and culture challenges

resource allocation disparities

Need for cultural awareness. Even with an interpreter present, there is a lack of understanding (e.g., Sudanese and Moroccan Arabic is not the same).

we need free english classes

Needs to be a prioritization on inclusion of Asian population's input and thoughts (more community sessions with interpreters)

Community isn't represented in education (health care system isn't diverse and representative)

Educational disparities and gaps related to racism

greater representation across levels (staff, leadership, board)

Priority Area 4: Access to Care

Resources/Assets

Community health centers, provide critical resources to the areas they serve

mobile clinics, ways to visit people

FQHCs are incredibly helpful in helping people link to services

Gaps/Barriers

Lack of public transportation

Long wait times, lack of information

we need support groups for families with children with autism

Learning new and better ways to provide services during the pandemic, need to sustain these to increase access to care

there needs to be more education on preventive care and resources availble

More information about mental health services available.

Patients don't have enough time with PCPs

Language and culture

Immigrant families don't know about the services available to them due to language barriers. (i.e., rental assistance - don't send information back in your own language)

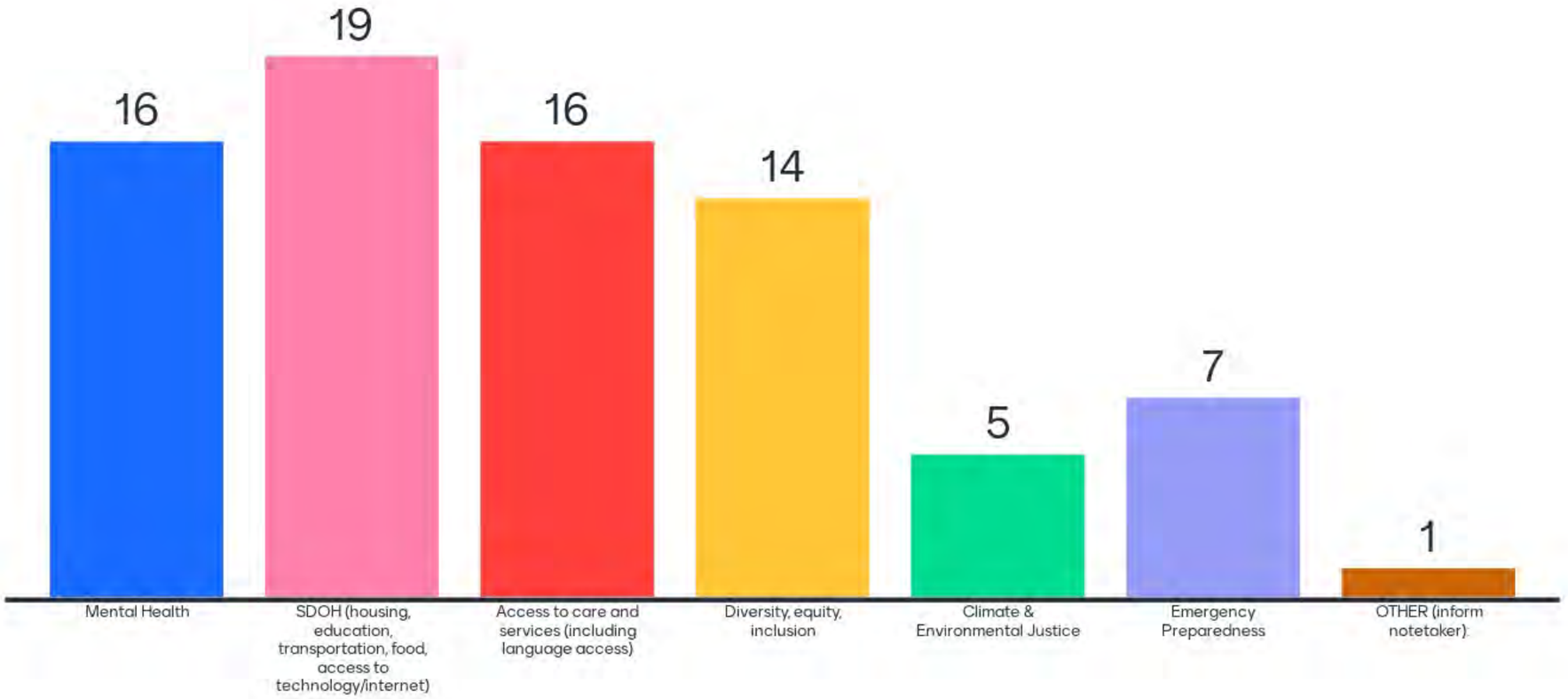
Transportation barriers, especially if you have to go downtown or travel a long distance

Lack of Insurance, especially for those who are unemployed or

Choose your top 4 priority areas.

Mentimeter

Results from 1/27/22 session



20

Notes from 1/27/22 session

Priority Area 1: Social Determinants of Health

Resources/Assets

Local Transfer tax

A neighborhood is a resource (where you live)

Community Development Corporations

Gaps/Barriers

teachers need to care more about students and be aware of how much time it takes to get work done

more time and support for balancing life in school

Guranteed income in Cambridge for eligible programs

Transportation is not reliable (timings, availability on weekends)

No one is woking together; duplication of efforts and spread thin. "There are MY clients." Everyone working in silos. A lot of ego involved, "I want this thing to have my name." +2

Event limitations due to COVID - lack of opportunity to socialize

Close collaboration between city and local organization, particularly in chelsea

Language is critical for outreach and services. Even when there is a language button, our people don't know where to find it, so aren't able to use it.

Need for more organized activities for immigrant elder population (non-english speaking)

Too much bureaucracy in getting $s out the door. Need better collaboration between those on the ground and the funders who pay for or support program. Too muc bureaucracy

Need for more safe, quality affordable housing. Put more houses than stores.

People shouldn't need to share housing - lack of personal space and privacy can lead to depression

Housing insecurity and issues lead to conflict and mental health issues in the community

Boston Hospitals should be advocates for affordable, safe housing and policies to support people stay in communities and own homes

Need more community outreach and advocacy. A lot of people don't know these resources are there.

Priority Area 2: Mental Health

Resources/Assets

- Pine Street Inn, Visitors Stone House
- counselor/family support office at schools
- Raising Black and Brown Children Program

Gaps/Barriers

- i don't think there's enough, mental health services aren't taken as serious as necessary in my opinion.
- Poor benefits to support MH and SU services, people are underinsured
- Hard to navigate the MH service system
- Youth mental health is a major issue
- Need for trauma informed services
- Need for screening and assessment to ensure that people are aware of their issues and get the care they need. A lot of people just are sure of their
- Stigma related to MH is a huge factor that prevents people from seeking care
- counselors at school seem like they don't care, only focused on grades
- Need for social and emotional learning in schools to address MH and trauma, particularly group / peer sessions
- Need services for homeless and for those who are housing insecure
- Limited clinicians who understand Asian communities.
- Needs to be more access to services and guidance on where to go, what is available, awareness of options is very low
- Need programs for those who are uninsured and facing material poverty
- Waiting lists and insurance coverage.
- no housing leads to high stress levels
- Stress about child care and childrens happiness

Priority Area 3: Access to Care

Resources/Assets

Need for more diverse teachers

Telehealth is a great asset

Gaps/Barriers

Stigma around need. Few want to admit they suffer from a disparity.

Undocumented immigrants struggle acutely with access due to lack of insurance and fear of accessing services.

COVID testing lines tell a story. Inner city lines were long, elderly standing in line in freezing weather.

Telephone bills are high for low income families - which reduces access to services

Calling hospitals to access interpreters takes too long and is very inefficient - this is a huge barrier to access for immigrant non-english populations

Address digital divide to promote equity in access to telehealth and resource inventories and support to navigate the system

Health insurance is very expensive and not accessible - people don't know how to navigate this system in english but they are expected to navigate without knowing english

Location of services and need for better transporation

Need to explore how to better leverage telehealth moving forward to take full advantage of opportunity. They shouldn't go away

Priority Area 4: Diversity, Equity, Inclusion

Resources/Assets

The "Family Van" goes to the community, offering BP, HIV testing, etc.

Fresh Truck brings healthy food to BIPOC communities.

Need for more forums for non-English speakers

Racial equity pledge with social service organizations led by CDCs in MA

Gaps/Barriers

we don't talk about this as much as we should

we tend to talk about this stuff with our friends, not family

We don't see poor people in the lines for the Fresh Truck as much as we would like. Stigma.

Not enough research on Asian communities, needs and issues.

Need for more diverse leaders to create sense of safety and inclusion

Undocumented immigrants are discriminated against

YOUTH

Resources/Assets

Gaps/Barriers

Appendix B:
Data Book

Secondary Data

Key

Significantly low compared to the Commonwealth based on margin of error

Significantly high compared to the Commonwealth overall based on margin of error

					Community Benefits Service Area								
	MA	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Burlington	Chelsea	Lexington	Needham	Newton	Peabody	Source
Population													US Census Bureau, American Community Survey 2016-2020
Total Population	6,873,003	1,605,899	703,740	801,162	689,326	59,223	28,077	39,878	33,304	31,177	88,322	53,004	
Female	51.5%	49.00%	51.90%	51.80%	52.0%	53.2%	51.5%	49.2%	51.1%	52.3%	53.0%	53.1%	
Male	48.5%	49.00%	48.10%	48.20%	48.0%	46.8%	48.5%	50.8%	48.9%	47.7%	47.0%	46.9%	
Age Distribution													US Census Bureau, American Community Survey 2016-2020
Under 5 years (%)	5.2%	5.3%	5.3%	5.2%	4.9%	4.8%	4.5%	8.0%	3.8%	4.8%	4.3%	6.2%	
5 to 9 years	5.3%	5.4%	5.5%	4.3%	4.1%	5.5%	7.1%	5.5%	6.3%	8.1%	5.9%	4.0%	
10 to 14 years	5.7%	5.6%	6.2%	4.4%	4.2%	6.0%	4.4%	6.8%	10.3%	8.9%	6.6%	4.8%	
15 to 19 years	6.6%	6.3%	6.4%	6.9%	7.1%	5.2%	4.2%	6.4%	8.2%	7.9%	10.0%	5.4%	
20 to 24 years	7.1%	7.0%	6.2%	9.6%	10.2%	10.2%	5.0%	6.6%	3.2%	4.1%	7.2%	6.4%	
25 to 34 years	14.3%	15.5%	12.9%	23.3%	24.4%	18.7%	12.0%	18.9%	3.8%	4.9%	9.1%	11.7%	
35 to 44 years	12.2%	13.2%	12.6%	12.9%	12.5%	12.6%	13.0%	16.7%	11.6%	12.9%	11.9%	10.0%	
45 to 54 years	13.3%	13.4%	14.1%	11.0%	10.6%	11.7%	13.6%	11.8%	19.8%	14.8%	14.1%	13.6%	
55 to 59 years	7.1%	7.0%	7.4%	5.5%	5.4%	4.7%	7.2%	5.1%	7.5%	8.2%	6.3%	8.9%	
60 to 64 years	6.5%	6.0%	6.5%	4.9%	4.7%	4.8%	7.0%	4.5%	5.0%	5.8%	6.3%	6.4%	
65 to 74 years	9.5%	8.7%	9.4%	6.9%	6.8%	8.9%	10.6%	5.5%	11.3%	10.2%	10.2%	10.2%	
75 to 84 years	4.6%	4.4%	4.8%	3.3%	3.3%	5.1%	7.5%	2.5%	5.8%	5.1%	5.1%	6.3%	
85 years and over	2.4%	2.3%	2.6%	1.8%	1.7%	2.0%	3.9%	1.7%	3.4%	4.2%	2.9%	6.0%	
Under 18 years of age	19.8%	19.8%	20.9%	16.6%	15.8%	19.0%	18.7%	24.5%	27.0%	27.3%	21.3%	18.3%	
Over 65 years of age	16.5%	15.3%	16.8%	12.0%	11.8%	16.0%	22.0%	9.7%	20.5%	19.5%	18.3%	22.6%	
Race/Ethnicity													US Census Bureau, American Community Survey 2016-2020
White alone (%)	76.6%	75.2%	76.1%	53.8%	52.1%	70.8%	76.1%	42.4%	63.1%	86.1%	76.0%	89.0%	
Black or African American alone (%)	7.5%	5.3%	7.2%	21.5%	24.2%	3.1%	2.4%	6.2%	1.3%	2.8%	3.0%	3.5%	
Asian alone (%)	6.8%	12.4%	11.3%	8.9%	9.8%	17.4%	16.3%	3.9%	30.6%	8.7%	15.2%	1.3%	
Native Hawaiian and Other Pacific Islander (%) alone	0.0%	0.1%	0.0%	0.0%	0.3%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	
American Indian and Alaska Native (%) alone	0.2%	0.2%	0.1%	0.3%	0.1%	0.2%	0.2%	0.1%	0.0%	0.1%	0.1%	0.2%	
Some Other Race alone (%)	4.2%	2.9%	1.7%	6.6%	6.3%	1.0%	0.3%	10.9%	1.0%	0.4%	1.8%	2.5%	
Two or More Races (%)	4.8%	4.0%	3.5%	8.8%	7.2%	7.5%	4.3%	36.4%	4.0%	1.9%	4.0%	3.5%	
Hispanic or Latino of Any Race (%)	12.0%	8.1%	4.7%	22.9%	19.5%	6.7%	1.5%	67.7%	1.9%	2.6%	4.5%	11.6%	
Race/Ethnicity of Students in Public Schools													School and District Profiles, Massachusetts Department of Elementary and Secondary Education, 2020-2021, B05006
African American (%)	9.3				29.3	6.2	7.9	4.5	3.9	3.2	4.6	6.4	
Asian (%)	7.2				9.1	20.0	28.2	0.1	41.8	10.2	20.0	19.6	
Hispanic (%)	22.3				42.4	10.8	35.0	87.7	4.8	6.1	8.2	7.5	
White (%)	56.7				15.3	52.2	24.8	6.2	42.2	74.8	59.3	60.7	
Native American (%)	0.2				0.3	-	-	0.2	0.1	0.1	0.1	-	
Native Hawaiian, Pacific Islander (%)	0.1				0.2	0.1	-	-	-	0.1	0.1	-	
Multii-Race, Non-Hispanic (%)	4.10				3.4	10.8	4.1	1.3	7.3	5.5	7.7	5.7	
Foreign-born	17.0%	21.3%	18.5%	29.7%	28.2%	29.0%	22.6%	47.1%	29.2%	13.8%	21.3%	15.6%	US Census Bureau, American Community Survey 2016-2020
Naturalized U.S. Citizen	54.2%	50.2%	60.6%	48.2%	50.0%	47.9%	54.1%	32.4%	58.9%	70.6%	64.3%	65.6%	
Not a U.S. Citizen	45.8%	49.8%	39.4%	51.8%	50.0%	52.1%	45.9%	67.6%	41.1%	29.4%	35.7%	34.4%	
Region of birth: Europe	20.0%	18.8%	23.0%	11.7%	11.8%	30.4%	17.6%	3.7%	16.3%	36.2%	31.3%	38.5%	
Region of birth: Asia	31.1%	43.8%	47.0%	23.4%	27.1%	54.9%	64.1%	5.9%	74.7%	43.8%	49.4%	7.3%	
Region of birth: Africa	9.3%	7.2%	7.3%	10.3%	10.8%	3.4%	8.9%	4.3%	1.9%	5.6%	5.3%	2.5%	
Region of birth: Oceania	0.3%	0.5%	0.3%	0.3%	0.3%	0.2%	1.8%	0.0%	0.3%	0.7%	0.6%	0.3%	
Region of birth: Latin America	36.7%	26.9%	20.1%	53.1%	48.5%	8.4%	4.5%	85.9%	3.8%	10.2%	10.6%	50.3%	
Region of birth: Northern America	2.5%	2.8%	2.3%	1.3%	1.5%	2.8%	3.1%	0.2%	3.1%	3.4%	2.9%	1.0%	
Language													US Census Bureau, American Community Survey 2016-2020
English only	76.1%	73.4%	77.8%	60.5%	62.9%	67.0%	76.5%	29.1%	64.1%	83.4%	74.5%	76.8%	
Language other than English	23.9%	26.6%	22.2%	39.5%	37.1%	33.0%	23.5%	70.9%	35.9%	16.6%	25.5%	23.2%	
Speak English less than "very well"	9.2%	9.0%	8.2%	18.6%	16.9%	9.2%	6.1%	40.2%	7.1%	5.0%	6.3%	9.6%	

Spanish	9.1%	5.8%	3.1%	19.3%	16.3%	4.7%	1.2%	60.9%	1.7%	2.2%	3.3%	8.0%	
Speak English less than "very well"	3.8%	2.1%	0.6%	9.6%	7.7%	0.5%	0.4%	35.2%	0.4%	0.3%	0.6%	4.2%	
Other Indo-European languages	9.0%	11.7%	9.1%	11.0%	11.1%	13.3%	14.2%	5.1%	11.8%	7.0%	10.4%	13.9%	
Speak English less than "very well"	3.0%	3.6%	2.8%	4.5%	4.4%	2.5%	3.1%	2.7%	1.3%	2.3%	2.5%	5.1%	
Asian and Pacific Islander languages	4.4%	7.4%	8.3%	6.7%	7.5%	11.5%	6.0%	2.5%	20.6%	4.8%	10.0%	0.9%	
Speak English less than "very well"	2.0%	2.9%	4.3%	3.7%	4.1%	5.2%	2.1%	1.5%	5.3%	2.0%	3.1%	0.2%	
Other languages	1.4%	1.7%	1.7%	2.4%	2.3%	3.4%	2.1%	2.4%	1.9%	2.5%	1.8%	0.4%	
Speak English less than "very well"	0.4%	0.5%	0.5%	0.8%	0.7%	1.0%	0.6%	0.9%	0.1%	0.5%	0.1%	0.1%	
Percent of public school student population that are English language learners (%)	10.5				29.2	9.4	5.0	35.7	8.1	3.2	5.4	9.3	Massachusetts Department of Elementary and Secondary Education, 2021-2022
Employment													US Census Bureau, American Community Survey 2016-2020
Unemployment rate	5.1%	4.2%	4.5%	6.8%	6.9%	3.1%	2.0%	6.2%	3.5%	4.4%	3.3%	4.1%	
Unemployment rate by race/ethnicity													
White alone	4.5%	3.9%	4.1%	5.3%	5.3%	2.9%	2.3%	4.0%	3.2%	4.3%	3.3%	3.8%	
Black or African American alone	8.3%	7.0%	8.2%	9.8%	9.9%	1.7%	0.0%	2.8%	0.0%	9.1%	10.0%	0.0%	
American Indian and Alaska Native alone	10.7%	12.1%	0.0%	8.7%	8.1%	0.0%	-	0.0%	0.0%	0.0%	0.0%	100.0%	
Asian alone	4.2%	4.1%	3.4%	6.1%	6.2%	3.2%	1.3%	0.0%	4.7%	4.5%	2.9%	0.0%	
Native Hawaiian and Other Pacific Islander alone	5.4%	14.6%	0.0%	1.9%	1.9%	-	0.0%	-	-	-	0.0%	-	
Some other race alone	8.3%	5.7%	5.8%	9.8%	10.9%	12.4%	0.0%	8.8%	0.0%	0.0%	0.1%	0.0%	
Two or more races	9.1%	5.6%	7.7%	9.1%	8.3%	3.8%	0.0%	9.4%	0.0%	3.5%	1.2%	17.3%	
Hispanic or Latino origin (of any race)	8.3%	6.0%	6.3%	8.7%	9.2%	4.5%	0.0%	8.1%	0.0%	11.5%	3.7%	4.7%	
Unemployment rate by educational attainment													
Less than high school graduate	9.7%	7.8%	8.2%	10.7%	11.2%	7.2%	0.0%	10.8%	0.0%	1.6%	2.5%	10.2%	
High school graduate (includes equivalency)	5.9%	5.1%	6.6%	8.5%	8.8%	6.4%	2.7%	4.9%	0.0%	0.0%	3.8%	4.6%	
Some college or associate's degree	4.5%	4.0%	3.6%	7.2%	7.4%	3.0%	0.9%	6.2%	5.6%	5.0%	7.0%	3.5%	
Bachelor's degree or higher	2.8%	2.7%	2.6%	3.4%	3.4%	2.8%	1.3%	4.0%	3.0%	3.2%	2.6%	2.2%	
Income and Poverty													US Census Bureau, American Community Survey 2016-2020
Median household income (dollars)	84,385	106,202	105,320	74,881	76,298	113,642	121,433	60,370	185,686	154,398	174,707	80,681	
Population living below the federal poverty line in the last 12 months													
Individuals	9.8%	7.20%	6.0%	17.4%	18.0%	10.8%	4.2%	19.1%	3.2%	2.4%	4.3%	7.7%	
Families	6.6%	4.50%	4.0%	12.6%	12.8%	4.9%	1.9%	15.8%	2.2%	1.9%	2.6%	5.4%	
Individuals under 18 years of age	12.2%	7.60%	5.4%	24.1%	25.0%	6.7%	3.0%	28.0%	2.5%	0.5%	3.0%	10.4%	
Individuals over 65 years of age	8.9%	7.50%	7.2%	18.9%	19.8%	11.0%	7.4%	19.9%	4.6%	5.8%	4.8%	9.0%	
Female head of household, no spouse present	20.5%	16.20%	14.4%	26.8%	27.1%	18.6%	6.3%	27.0%	18.6%	4.6%	10.5%	18.1%	
White alone	7.9%	6.00%	5.1%	12.5%	12.5%	9.3%	4.4%	16.4%	2.6%	2.1%	3.6%	7.2%	
Black or African American alone	17.6%	14.6%	11.2%	21.0%	21.2%	19.7%	13.3%	20.7%	1.2%	2.7%	6.7%	13.5%	
American Indian and Alaska Native alone	23.3%	26.9%	7.4%	24.1%	25.3%	10.8%	0.0%	0.0%	0.0%	0.0%	46.2%	0.0%	
Asian alone	11.8%	9.4%	7.7%	27.2%	27.9%	14.5%	3.2%	19.3%	4.9%	4.4%	7.2%	1.5%	
Native Hawaiian and Other Pacific Islander alone	11.9%	14.6%	2.6%	4.9%	4.9%	-	0.0%	-	-	-	0.0%	-	
Some other race alone	22.2%	14.7%	10.9%	26.5%	29.7%	26.3%	1.1%	18.1%	3.8%	1.7%	6.9%	23.6%	
Two or more races	15.5%	8.7%	7.7%	20.8%	21.5%	10.9%	0.2%	22.3%	0.8%	2.2%	2.2%	5.9%	
Hispanic or Latino origin (of any race)	23.0%	17.3%	11.5%	24.0%	27.2%	12.7%	12.0%	20.0%	6.7%	0.5%	7.8%	17.8%	
Less than high school graduate	23.2%	18.4%	15.8%	29.6%	32.2%	21.1%	7.0%	25.6%	18.5%	6.7%	9.2%	12.4%	
High school graduate (includes equivalency)	11.7%	10.6%	9.2%	18.8%	20.2%	30.3%	4.7%	16.3%	7.4%	4.2%	11.7%	10.3%	
Some college, associate's degree	8.4%	7.1%	6.6%	14.0%	14.8%	18.1%	6.0%	15.3%	11.6%	3.8%	4.9%	5.8%	
Bachelor's degree or higher	3.9%	3.5%	3.1%	7.2%	7.3%	5.7%	4.2%	5.8%	2.1%	2.3%	3.1%	3.6%	
With Social Security	30.2%	26.3%	29.5%	21.4%	20.2%	22.9%	36.6%	24.2%	29.3%	32.6%	29.4%	39.7%	
With retirement income	19.3%	17.4%	19.7%	11.1%	10.6%	13.5%	24.2%	8.4%	20.3%	22.4%	18.7%	26.3%	
With Supplemental Security Income	5.9%	4.0%	3.5%	7.6%	7.7%	2.3%	2.7%	8.8%	1.2%	3.1%	3.6%	5.5%	
With cash public assistance income	2.8%	2.0%	1.9%	3.3%	3.3%	1.7%	0.7%	3.9%	1.4%	1.9%	1.8%	3.0%	
With Food Stamp/SNAP benefits in the past 12 months	11.6%	6.7%	6.7%	16.6%	16.8%	6.3%	3.7%	20.0%	2.0%	2.7%	3.8%	10.3%	
Housing													US Census Bureau, American Community Survey 2016-2020
Occupied housing units													
Owner-occupied	62.5%	62.1%	68.8%	36.3%	35.3%	48.5%	75.0%	26.9%	81.7%	84.5%	71.5%	65.2%	
Renter-occupied	37.5%	37.9%	31.2%	63.7%	64.7%	51.5%	25.0%	73.1%	18.3%	15.5%	28.5%	34.8%	
Lacking complete plumbing facilities	0.3%	0.3%	0.2%	0.4%	0.3%	0.2%	0.1%	0.9%	0.2%	0.4%	0.3%	0.8%	
Lacking complete kitchen facilities	0.8%	0.8%	0.7%	0.8%	0.8%	1.1%	1.6%	1.4%	0.9%	0.8%	0.6%	3.4%	
No telephone service available	1.2%	1.0%	1.0%	1.7%	1.7%	1.1%	0.8%	2.0%	0.7%	1.2%	0.2%	1.6%	
Monthly housing costs >35% of total household income													

Among owner-occupied housing units with a mortgage	22.0%	20.5%	21.2%	25.9%	24.8%	24.6%	18.1%	35.3%	17.5%	18.2%	24.3%	22.0%	
Among owner-occupied units without a mortgage	15.2%	15.4%	16.4%	16.2%	15.5%	19.8%	11.5%	13.6%	17.0%	9.8%	15.1%	15.2%	
Among occupied units paying rent	39.1%	35.1%	37.5%	40.2%	39.6%	33.9%	43.5%	41.7%	40.9%	39.3%	28.2%	45.1%	
Eviction filings, 2018	37,500	5,400	2000	6500	5600	79	46	363	31	37	111	286	Eviction lab, 2018
Access to Technology													US Census Bureau, American Community Survey 2016-2020
Among households													
Has desktop or laptop	82.2%	87.6%	87.1%	79.7%	80.6%	92.4%	90.3%	66.9%	95.5%	91.7%	92.5%	78.2%	
Has smartphone	83.3%	85.9%	85.4%	86.1%	86.6%	90.5%	84.8%	85.3%	88.2%	84.4%	89.2%	78.6%	
Has tablet or other portable wireless computer	64.8%	69.5%	70.3%	60.0%	60.3%	71.0%	73.7%	53.9%	77.3%	76.0%	75.0%	61.9%	
No computer	7.4%	5.8%	5.4%	7.8%	7.5%	3.8%	5.4%	10.0%	3.1%	4.4%	4.3%	11.4%	
With broadband internet	88.2%	91.3%	91.5%	86.7%	87.1%	93.6%	93.7%	82.7%	96.5%	93.6%	94.7%	84.9%	
Transportation													US Census Bureau, American Community Survey 2016-2020
Mode of transportation to work for workers aged 16+													
Car, truck, or van -- drove alone	68.0%	64.10%	65.00%	39.60%	37.50%	30.70%	79.10%	46.00%	69.00%	66.70%	58.50%	84.20%	
Car, truck, or van -- carpooled	7.3%	6.70%	6.30%	6.50%	5.70%	4.50%	6.70%	13.40%	5.60%	3.90%	6.70%	7.20%	
Public transportation (excluding taxicab)	9.5%	11.40%	13.50%	30.00%	30.70%	26.80%	4.40%	26.80%	6.60%	12.80%	12.90%	3.10%	
Walked	4.8%	4.90%	3.60%	13.20%	14.60%	16.20%	1.10%	5.70%	2.20%	2.90%	6.50%	1.00%	
Other means	2.1%	2.70%	1.70%	3.80%	4.00%	7.00%	0.20%	3.70%	2.30%	1.00%	1.50%	1.40%	
Worked from home	8.3%	10.20%	9.90%	6.90%	7.30%	14.80%	8.50%	4.50%	14.30%	12.70%	13.90%	3.20%	
Mean travel time to work (minutes)	30	31.1	34.6	31.1	30.7	29.1	29.7	33.9	31.1	32.5	28.4	27.4	
Vehicles available among occupied housing units													
No vehicles available	12.2%	10.5%	9.3%	31.9%	33.5%	30.0%	3.3%	28.9%	4.1%	6.4%	6.1%	11.9%	
1 vehicle available	35.1%	35.1%	33.5%	42.6%	42.5%	46.0%	27.6%	45.3%	24.9%	21.7%	33.1%	32.9%	
2 vehicles available	36.1%	38.6%	40.5%	19.7%	18.8%	20.3%	47.0%	18.4%	54.1%	53.7%	47.2%	38.2%	
3 or more vehicles available	16.5%	15.8%	16.7%	5.8%	5.3%	3.7%	22.1%	7.4%	16.9%	18.3%	13.6%	17.0%	
Education													US Census Bureau, American Community Survey 2016-2020
Educational attainment of adults 25 years and older													
Less than 9th grade (%)	4.2%	3.2%	2.6%	7.5%	6.8%	1.5%	2.0%	21.6%	0.5%	0.9%	1.6%	5.3%	
9th to 12th grade, no diploma (%)	4.7%	3.2%	3.3%	5.6%	5.4%	1.3%	1.7%	9.8%	0.9%	1.2%	1.0%	3.9%	
High school graduate (includes equivalency) (%)	23.5%	18.5%	18.7%	21.0%	18.9%	6.2%	18.9%	29.4%	5.5%	8.4%	7.8%	29.9%	
Some college, no degree (%)	15.3%	12.2%	13.5%	13.3%	13.0%	5.5%	12.4%	13.8%	5.0%	7.3%	7.1%	17.1%	
Associate's degree (%)	7.7%	5.9%	7.3%	4.8%	4.6%	2.0%	6.5%	5.5%	3.1%	4.1%	3.7%	9.2%	
Bachelor's degree (%)	24.5%	28.1%	28.8%	26.3%	27.8%	29.0%	34.9%	12.8%	25.7%	31.1%	29.4%	22.9%	
Graduate or professional degree (%)	20.0%	28.9%	25.8%	21.4%	23.5%	54.6%	23.6%	7.0%	59.2%	47.1%	49.3%	11.7%	
High school graduate or higher (%)	91.1%	93.7%	94.1%	86.9%	87.9%	97.2%	96.3%	68.6%	98.6%	97.9%	97.3%	90.8%	
Bachelor's degree or higher (%)	44.5%	57.1%	54.6%	47.7%	51.0%	83.6%	58.5%	19.9%	84.9%	78.1%	78.7%	34.6%	
Educational attainment by race/ethnicity													
White alone, not Hispanic/Latino													
High school graduate or higher	94.5%	95.9%	96.5%	96.1%	96.8%	99.3%	96.7%	89.6%	98.8%	98.2%	98.0%	93.5%	
Bachelor's degree or higher	47.7%	58.5%	55.9%	66.6%	72.3%	86.0%	53.3%	38.1%	83.9%	78.7%	79.3%	36.6%	
Black alone													
High school graduate or higher	86.2%	89.9%	88.9%	84.6%	84.4%	73.5%	93.6%	81.9%	92.0%	93.2%	90.3%	90.5%	
Bachelor's degree or higher	27.6%	36.1%	36.9%	23.5%	23.2%	38.8%	70.7%	19.7%	83.2%	50.2%	65.9%	20.3%	
American Indian or Alaska Native alone													
High school graduate or higher	81.0%	83.0%	81.3%	82.5%	83.2%	53.9%	100.0%	100.0%	100.0%	100.0%	100.0%	76.7%	
Bachelor's degree or higher	21.9%	18.5%	28.6%	28.6%	28.8%	10.8%	0.0%	22.0%	0.0%	100.0%	7.3%	0.0%	
Asian alone													
High school graduate or higher	85.7%	90.0%	83.3%	79.2%	79.4%	94.5%	94.7%	66.1%	98.1%	95.9%	97.4%	92.3%	
Bachelor's degree or higher	61.8%	70.4%	57.9%	53.5%	54.4%	83.7%	81.2%	24.1%	87.4%	81.6%	82.7%	59.4%	
Native Hawaiian and Other Pacific Islander alone													
High school graduate or higher	89.1%	95.3%	76.3%	83.9%	83.9%	-	100.0%	-	-	-	100.0%	-	
Bachelor's degree or higher	36.4%	25.5%	52.6%	50.9%	50.9%	-	0.0%	-	-	-	0.0%	-	
Some other race alone													
High school graduate or higher	69.9%	72.1%	83.7%	72.3%	72.9%	99.0%	83.6%	62.1%	100.0%	100.0%	75.9%	60.7%	
Bachelor's degree or higher	15.7%	20.2%	33.0%	19.8%	21.9%	80.9%	83.6%	12.6%	88.7%	38.8%	39.4%	14.4%	
Two or more races													

High school graduate or higher	81.3%	89.7%	91.6%	67.6%	73.9%	94.7%	99.8%	49.8%	99.8%	88.4%	95.1%	83.7%	
Bachelor's degree or higher	34.9%	52.7%	61.1%	29.7%	37.8%	82.5%	87.1%	8.2%	88.1%	79.3%	74.3%	27.1%	
Hispanic or Latino Origin													
High school graduate or higher	72.4%	77.8%	91.3%	70.2%	71.9%	96.0%	85.2%	58.4%	99.8%	98.5%	87.6%	67.0%	
Bachelor's degree or higher	20.9%	32.1%	46.8%	22.4%	25.7%	81.5%	35.4%	11.8%	83.3%	73.4%	59.5%	17.7%	
Graduation rate of public high school students (%)	89.00				75.40	94.50	94.4	66.30	96.6	98.50	96.00	88.0	Massachusetts Department of Elementary and Secondary Education, 2020
Safety/Crime													Massachusetts Crime Statistics, 2021
Property crime rate (total count)													
Burglary	9,592				1300	61	18	84	19	21	74	49	
Larceny-theft	55,672				9312	479	256	552	89	99	416	364	
Motor vehicle theft	7,045				1163	29	13	60	5	5	21	36	
Arson	312				26	0	2	4	0	1	0	2	
Rate of offenses known to law enforcement (total count)													
Murder/non-negligent manslaughter	151				38	0	0	2	0	-	0	0	
Sex offenses	4,171				385	4	15	84	2	6	13	22	
Assaults	67,690				14,137	136	124	737	74	66	165	394	
Access to Care													
Ratio of population to primary care physicians	960 to 1	780 to 1	780 to 1	650 to 1									County Health Rankings, 2019
Ratio of population to mental health providers	140 to 1	160 to 1	150 to 1	110 to 1									County Health Rankings, 2021
Ratio of population to dentists	930 to 1	980 to 1	800 to 1	450 to 1									County Health Rankings, 2020
Health insurance coverage among civilian noninstitutionalized population (%)													US Census Bureau, American Community Survey 2016-2020
With health insurance coverage	97.3%	97.4%	98.2%	96.2%	96.5%	98.3%	97.5%	93.6%	99.0%	98.7%	98.6%	97.2%	
With private health insurance	74.5%	81.0%	82.9%	66.5%	68.3%	87.1%	82.2%	44.2%	91.6%	89.3%	88.5%	76.4%	
With public coverage	36.1%	28.5%	28.4%	37.9%	36.0%	20.5%	31.3%	55.8%	22.6%	24.8%	23.4%	39.8%	
No health insurance coverage	2.7%	2.6%	1.8%	3.8%	3.5%	1.7%	2.5%	6.4%	1.0%	1.3%	1.4%	2.8%	

Key

					Community Benefits Service Area								
	MA	Middlesex County	Norfolk County	Suffolk County	Boston	Brookline	Burlington	Chelsea	Lexington	Needham	Newton	Peabody	Source
Overall Health													
Mortality rate (age-adjusted per 100,000)	654	574.2	594.7	600.4	602.1	418.5	526	807	392.2	501.3	428.6	622.7	Massachusetts Death Report, 2019
Premature deaths (per 100,000)	272.8	210.4	228.8	262.8	263.9	136.6	209.4	393.1	133.6	149	122.5	267.4	
Leading causes of death (counts)													
Cancer	12,584	2613	1392	962	770	74	44	49	47	52	128	120	
Heart Disease	11,779	2426	1160	909	723	67	57	50	45	37	147	161	
Chronic Lower Respiratory Disease	2,842	474	249	192	140	9	9	12	8	11	10	25	
Stroke	2,463	454	255	195	169	14	9	7	12	7	21	28	
Disability													US Census Bureau, American Community Survey 2016-2020
Percent of population with a disability	11.7%	9.5%	9.5%	11.9%	11.8%	7.0%	10.0%	12.5%	7.2%	7.4%	8.2%	16.0%	
Under 18	4.7%	3.8%	3.2%	5.7%	5.7%	1.2%	3.1%	5.0%	2.9%	2.0%	3.5%	2.8%	
18-64	8.9%	6.6%	6.8%	8.8%	8.8%	4.0%	5.8%	10.0%	4.6%	3.9%	4.9%	10.5%	
65+	31.3%	29.3%	27.8%	39.5%	39.3%	26.3%	27.2%	52.1%	20.1%	25.0%	25.0%	41.8%	
Healthy Living													
Adults over 18 with no leisure-time physical activity (age-adjusted) (%)	26	22	26	29									Behavioral Risk Factor Surveillance System, 2019
Adults who participated in enough aerobic and muscle strengthening exercises to meet guidelines (%)	22.2												Behavioral Risk Factor Surveillance System, 2019
Population with adequate access to locations for physical activity (%)	89	95	88	100									County Health Rankings, 2021
Adults who consumed vegetables at least one time per day (%)	84.5												Behavioral Risk Factor Surveillance System, 2019
Adults who consumed fruits at least one time per day (%)	67.3												Behavioral Risk Factor Surveillance System, 2019
Adults who consumed fruit less than one time per day (%)	32.7												Behavioral Risk Factor Surveillance System, 2019
Population with limited access to healthy foods (%)	4	3	4	0									USDA Food Environment Atlas, 2019
Total Population that Did Not Have Access to a Reliable Source of Food During Past Year (food insecurity rate) (%)	8.2												Feeding America, Map the Meal Gap, 2019
Percentage of adults who report fewer than 7 hours of sleep on average (age-adjusted) (%)	34	33	35	38									Behavioral Risk Factor Surveillance System, 2018
Mental Health													
Average number of mentally unhealthy days in past 30 days (adults)	4.2	4	4.1	4.4									County Health Rankings, 2019
Youth Risk Behavior Survey (YRBS)													Youth Risk Behavior Survey - Report years indicated
	2019				**2019**	**2017**	**2021**		**2019**	**2016 MS/2018 HS**	**2018**		
% of students (grades 6-8) bullied on school property (%)	35.3				20.5 (ever)	13.0	22.1 (ever)		--	9.7	15.4		
% of students (grades 6-8) bullied electronically (%)	15.2				11.2	13.0	18.2 (ever)		--	14.2	11.1		
% of students (grades 9-12) bullied on school property (%)	16.3				9.1	7.0	4.6		--	11.3	8.3		
% of students (grades 9-12) bullied electronically (%)	13.9				--	14.0 (ever)	8.0		--	15.1	8.3		
% of students (grades 6-8) reporting self harm (%)	21				15.0	--	16.3		10.7	4.9	5.7		
% of students (grades 9-12) reporting self harm (%)	16.4				22.8 (ever)	14.0	15.8		15.5	9.1	11.6		
% of students (grades 6-8) reporting suicide ideation (%)	11.3				15.6	4.0	3.7		--	7.6	8.2		
% of students (grades 9-12) reporting suicide ideation (%)	17.5				11.2 (ever)	4.0	11.1		--	6.7	10.4		
% of students (grades 6-8) reporting suicide attempt (%)	5				9.3	<1	10.6		16.6	1.1	1.1		
% of students (grades 9-12) reporting suicide attempt (%)	7.3				--	--	2.4		--	2.2	3.0		
Substance Use													
Admissions to DPH-funded treatment programs (count)	98944				14780	0-100	105	677	0-100	0-100	227	737	MA DPH, Bureau of Substance Abuse Services, 2017
Rate of injection drug user admissions to DPH-funded treatment program (%)	52.4				52.9	68.2	47.6	58.8	53.8	72.9	56.8	42.6	
Primary substance of use when entering treatment													
Alcohol (%)	32.8				29.9	47.7	38.1	31.5	26.9	50.8	44.5	28.9	
Crack/Cocaine (%)	4.1				4.5	-	-	4.3	-	-	2.6	4.3	
Heroin (%)	52.8				56.9	31.8	48.6	53.2	48.1	30.5	41	52.9	
Marijuana (%)	3.5				3	10.2		7.1	-	-	4.8	3.9	
Other Opioids (%)	4.6				2.4	-	-	2.4	-	-	4.4	6.5	
Other Sedatives/Hypnotics (%)	1.5				2.1	-	-	-	-	-	-	2.4	
Other Stimulants (%)	0.5				1	-	-	-	-	-	-	-	
Other (%)	0.3				0.3	-	-	-	-	-	-	-	
Adults who report current smoking status (%)	12	12	12	13									Behavioral Risk Factor Surveillance System, 2019
Adults who report excessive drinking (binge or heavy drinking) (%)	22	23	26	22									Behavioral Risk Factor Surveillance System, 2019
Youth Risk Behavior Survey (YRBS) - report year indicated	**2019**				**2019**	**2017**	**2021**		**2019**	**2018**	**2018**		Youth Risk Behavior Survey; Years indicated in line
Students (grades 6-8) reporting lifetime alcohol use (%)	13.6				21.0	11.0	7.4		28.0	8.9	7.9		
Students (grades 6-8) reporting current alcohol use (%)	4.4				5.4	4.0	2.2		3.1	2.9	1.7		
Students (grades 9-12) reporting lifetime alcohol use (%)	--				--	36.0	36.8		56.0	49.0	56.5		
Students (grades 9-12) reporting current alcohol use (%)	29.8				21.2	30.0	16.9		20.6	29.2	31.1		
Students (grades 6-8) reporting current binge alcohol use (%)	0.9				--	--	--		--	0.5	0.0		
Students (grades 9-12) reporting current binge alcohol use (%)	15.0				9.8	13.0	7.2		13.9	18.5	16.7		
Students (grades 6-8) reporting lifetime cigarette use (%)	5.2				--	3.0	1.1		1.3	1.5	1.6		
Students (grades 6-8) reporting current cigarette use (%)	--				1.4	--	0.2		0.3	0.3	0.0		
Students (grades 9-12) reporting lifetime cigarette use (%)	17.7				--	17.0	8.2		8.8	10.8	14.5		
Students (grades 9-12) reporting current cigarette use (%)	5.0				2.8	5.0	1.8		2.9	2.4	3.0		
Students (grades 6-8) reporting lifetime marijuana use (%)	7.0				8.0	2.0	1.8		1.1	1.4	1.4		
Students (grades 6-8) reporting current marijuana use (%)	3.0				5.9	1.0	0.5		0.5	1.2	0.4		
Students (grades 9-12) reporting lifetime marijuana use (%)	41.9				--	26.0	16.1		19.0	28.6	40.4		
Students (grades 9-12) reporting current marijuana use (%)	26.0				22.6	17.0	7.3		13.5	19.6	25.4		
Students (grades 6-8) reporting lifetime electronic tobacco use (%)	14.7				--	--	4.2		4.3	5.1	4.4		

Students (grades 6-8) reporting current electronic tobacco use (%)	--				7.6	--	1.1		1.8	2.6	2.2		
Students (grades 9-12) reporting lifetime electronic tobacco use (%)	50.7				--	--	20.2		24.8	34.6	32.1		
Students (grades 9-12) reporting current electronic tobacco use (%)	32.2				12.2	--	9.2		15.2	22.5	18.4		
Chronic Disease (more data on CHIA data tabs)													
Cancer mortality (all types, age-adjusted rate per 100,000)	149.92	140.37	144.67	147.38									Massachusetts Cancer Registry, 2014-2018
Cancer incidence (age-adjusted per 100,000)													
All sites	498.16	483.79	478.46	462.14									
Breast Cancer	176.35	189.2	196.7	150.1									
Cervical Cancer	5.5	4.66	4.17	5.5									
Coloretal Cancer	35.96	35.38	36.22	32.76									
Lung and Bronchus Cancer	61.41	54.88	60.42	59.62									
Risk factors													
Percent of Adults who are Obese (%)	26				23.4	21.8	20	26	17.4	21.5	19.1	30.1	Behavioral Risk Factor Surveillance System, 2018
Diagnosed diabetes among adults aged >=18 years (%)	8.6				10	6.5	6.4	11.4	5.7	5.6	5.9	7.9	Behavioral Risk Factor Surveillance System, 2018
Adults ever told by doctor that they had angina or coronary heart disease (age-adjusted) (%)	4.7				5.7	4.3	4.4		3.8	4	4	5.5	Behavioral Risk Factor Surveillance System, 2017
Adults ever told by doctor that they had high blood pressure (age adjusted) (%)	26.8				28.5	24.8	23.7		21.9	23.8	22.6	27.5	Behavioral Risk Factor Surveillance System, 2017
Adults ever told by doctor that they had high cholesterol (age-adjusted) (%)	33.1				29.8	28.8	26.4	31.4	25.6	28.3	25.8	29.6	Behavioral Risk Factor Surveillance System, 2017
Reproductive Health													
Infant Mortality Rate (per 1,000 live births)	3.7	2.8	2.9	4.3									March of Dimes, 2019
Low birth weight (%)	7.4	7	7.2	7.4									March of Dimes, 2020
Mothers with late or no prenatal care (%)	3.9%	3.4	3	5.2									March of Dimes, 2020
Births to adolescent mothers (per 1,000 females ages 15-19)	8	4	2	9									National Center for Health Statistics, 2014-2020
Percent of mothers receiving publicly funded prenatal care 2016	38.60%												Massachusetts Births 2016
Women screened for postpartum depression within 6 months after delivery (%)													MDPH January 2016-December 2016
White (non-Hispanic)	13.60%												
Black (non-Hispanic)	9.70%												
Asian or Pacific Islander (non-Hispanic)	14.60%												
American Indian/Alaska Native (non-Hispanic)	10.30%												
Other race (non-Hispanic)	13.30%												
Unknown race	12.40%												
Less than a high school diploma	8.00%												
With a high school diploma or GED	9.30%												
Some College/Associate Degree	11.40%												
Bachelor Degree	14.10%												
Graduate Degrees	15.20%												
Among individuals who had a full-term birth	12.10%												
Among individuals who had a pre-term birth	11.50%												
Among individuals who are not married	9.70%												
Among individuals who are married	13.70%												
Frequency of self-reported postpartum depressive symptoms 2017													MDPH 2019. CY18 Summary of Activities Related to Screening for Postpartum Depression
Rarely/Never	61.40%												
Often/Always	10.70%												
Sometimes	27.90%												
Communicable and Infectious Disease													
HIV prevalence (per 100,000 population 13 years and older)	355	288	234	814									National Center for HIV/AIDS, Viral Hepatitis, STD, TB Prevention, 2019
STI infection cases													Massachusetts Population Health Information Tool, 2018
Syphillis (case count)	1,164				317	Less than 5	Less than 5	15	Less than 5	Less than 5	9	Less than 5	MA DPH PHIT 2018
Gonorrhea (case count)	7,629				2119	51	9	80	6	6	56	31	
Chlamydia	30,297				6201	156	58	333	48	48	236	144	
Confirmed and probable Hepatitis B cases (per 100,000 population)	25.1												
Rate of Hepatitis C (per 100,000)	97.9				103	28.3	36.7	88.2	14.8	17.1	30.8	43.4	
Tuberculosis (case count)	204				34	1	Less than 5	Less than 5	Less than 5	Less than 5	1	1	
Medicare enrollees that had annual flu vaccination (%)	56%	59%	59	49									

***Supressed**

		Community Benefits Service Area											
	MA	**Middlesex County**	**Norfolk County**	**Suffolk County**	**Boston**	**Brookline**	**Burlington**	**Chelsea**	**Lexington**	**Needham**	**Newton**	**Peabody**	*Source*
COVID-19 Community Impact Survey													MDPH COVID-19 Community Impact Survey, updated November 2021. Note that these unweighted percentages represent rates of response of individuals that completed the survey in those geographies, and may not be represenative of those geographies as a whole.
% very worried about getting infected with COVID-19	27%	28%	27%	34%	33%	27%	22%	44%	29%	10%	30%	36%	
% ever been tested for COVID	39%	48%	42%	58%	55%	44%	39%	64%	38%	38%	40%	35%	
% who have not gotten the medical care they needed since July 2020	19%	19%	14%	20%	21%	16%	11%	6%	15%	15%	14%	18%	
% with 15 or more of poor mental health days in the past 30 days (unweighted %)	35%	32%	29%	34%	35%	25%	22%	31%	16%	16%	29%	34%	
% of substance users who said they are now using more substances than before the pandemic		42%	39%	42%	42%	37%	34%	40%	35%	31%	41%	41%	
% Worried about paying for 1 or more types of expense or bills in the coming few weeks (unweighted %)	46%	31%	34%	44%	43%	22%	34%	57%	17%	15%	22%	47%	
% Worried about getting food or groceries in the coming weeks (unweighted %)	25%	18%	19%	24%	24%	12%	20%	39%	17%	12%	13%	28%	
% Worried about getting face masks in the coming weeks (unweighted %)	13%	11%	11%	16%	17%	7%	8%	23%	8%	4%	9%	11%	
% Worried about getting medication in the coming weeks (unweighted %)	14%	10%	10%	12%	12%	7%	9%	18%	11%	6%	10%	15%	
% Worried about getting broadband in the coming weeks (unweighted %)	11%	9%	8%	13%	13%	6%	7%	23%	6%	4%	6%	15%	
% of Employed residents who experienced job loss (unweighted %)	8%	37%	44%	37%	7%	5%	*	*	*	8%	6%	9%	
% of employed residents who experienced reduced work hours (unweighted %)	12%	12%	11%	13%	13%	10%	14%	11%	9%	15%	9%	16%	
% Worried about paying mortgage, rent, or utilities related expenses (unweighted %)	34%	21%	24%	33%	33%	17%	21%	46%	9%	11%	14%	40%	
% Worried they may have to move out of where they live in the next few months (unweighted %)	17%	17%	14%	20%	21%	13%	*	*	*	15%	10%	19%	
COVID-19 Layoff													Planning Council, The COVID-19 Layoff Housing Gap (October 2020)
Estimated number of households in need of assistance with no government aid (without any unmployment benefits)					23148.18	727.18	478	1685.31	354.94	394.08	1192.15	1,543	
Total number of continuous unemployment claims as of 9/5 (from DUA)					42072	1487	1,009	3253	723	811	2425	3,119	

Community Health Needs Assessment - Beth Israel Deaconess Medical Center

Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume
Patients aged 0-17, BIDMC Community Benefits Service Area defined by BILH Community Benefits
Boston includes zip codes 02111, 02115, 02118, 02119, 02120, 02121, 02122, 02124, 02125, 02134, 02135, 02163, 02215, Brookline includes zip codes 02445 and 02446

		BIDMC Community Benefits Service Area							
	MA	Boston	Brookline	Burlington	Chelsea	Chestnut Hill	Lexington	Needham	Peabody
All Cause									
FY19 Inpatient Discharges (all cause) rate per 100,000 ages 0 - 17	1,735	2,969	1,557	1,519	2,433	1,264	1,251	1,403	2,253
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	-7%	-4%	-22%	-24%	-14%	-50%	-5%	20%	10%
FY19 ED Volume (all cause) rate per 100,000 ages 0 - 17	19,530	25,129	10,703	12,362	21,932	9,458	11,890	12,933	23,636
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	-1%	-5%	-7%	1%	0%	-7%	-13%	-6%	17%
Chronic Disease									
Asthma									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	333	597	230	319	576	195	139	249	615
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	-12%	-23%	-22%	-23%	-19%	14%	-44%	46%	37%
FY19 ED Volume rate per 100,000 ages 0 - 17	2,481	4,645	1,426	1,651	3,468	1,094	1,374	1,403	2,806
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	2%	-7%	-10%	42%	-17%	10%	37%	-4%	1%
Diabetes Mellitus									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	53	44	44	19	98	0	15	39	125
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	7%	-47%	-50%	-88%	67%	-100%	-80%	0%	140%
FY19 ED Volume rate per 100,000 ages 0 - 17	117	138	88	75	147	73	0	105	219
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	-2%	-17%	300%	-33%	15%	-25%	-100%	14%	320%
Obesity									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	61	130	22	19	156	0	15	13	42
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	6%	18%	-33%	-50%	-41%	-100%	-75%	0%	-60%
FY19 ED Volume rate per 100,000 ages 0 - 17	81	90	11	0	420	24	15	26	10
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	0%	14%	-50%	-100%	8%	0%	-50%	0%	-92%
Injuries and Infections									
Allergy									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	125	152	66	169	117	97	108	52	198
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	2%	-26%	20%	-25%	-37%	-43%	133%	-43%	36%
FY19 ED Volume rate per 100,000 ages 0 - 17	1,874	1,915	921	2,157	2,267	1,143	1,961	1,902	4,610
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	-1%	-45%	-58%	77%	-31%	-41%	-7%	11%	163%
HIV Infection									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	1	9	0	0	0	0	15	0	10
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	18%	300%	0%	0%	0%	0%	0%	0%	0%
FY19 ED Volume rate per 100,000 ages 0 - 17	1	18	0	0	0	0	0	0	10
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	-23%	700%	0%	0%	0%	0%	0%	0%	0%
Infections									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	767	1,460	779	657	1,163	997	340	538	699
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	-2%	6%	-8%	-8%	-11%	-35%	0%	3%	-11%
FY19 ED Volume rate per 100,000 ages 0 - 17	7,457	10,401	2,752	3,414	11,704	2,772	2,440	2,518	9,857
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	4%	-10%	-12%	1%	0%	-7%	-11%	-9%	34%
Injuries									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	345	536	241	338	381	340	216	262	344
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	-4%	1%	-35%	50%	-9%	-7%	-18%	-13%	10%
FY19 ED Volume rate per 100,000 ages 0 - 17	7,024	8,150	5,055	5,083	5,100	4,449	5,652	6,663	7,896
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	-8%	2%	-7%	-13%	-5%	3%	-19%	-3%	-1%
Poisonings									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	85	114	33	56	68	0	77	13	63
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	-30%	-26%	0%	200%	17%	-100%	67%	-67%	-33%

FY19 ED Volume rate per 100,000 ages 0 - 17	501	325	197	319	1,065	195	216	210	2,295
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	32%	16%	29%	42%	160%	100%	-26%	-16%	307%
Pneumonia/Influenza									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	213	389	110	413	342	219	139	157	438
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	3%	7%	-52%	0%	-19%	-10%	80%	0%	56%
FY19 ED Volume rate per 100,000 ages 0 - 17	1,098	1,032	285	769	957	122	448	590	1,346
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	38%	35%	53%	46%	13%	-55%	45%	88%	26%
Sexually Transmitted Diseases									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	4	11	0	0	0	0	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	7%	-17%	0%	0%	0%	0%	0%	0%	0%
FY19 ED Volume rate per 100,000 ages 0 - 17	35	121	0	0	39	0	0	0	31
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	15%	22%	-100%	0%	-20%	0%	-100%	0%	0%
Other									
Attention Deficit Hyperactivity Disorder									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	141	160	77	19	147	73	185	223	282
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	-3%	-8%	0%	-91%	-21%	-40%	-8%	89%	-25%
FY19 ED Volume rate per 100,000 ages 0 - 17	588	861	428	394	186	389	309	564	636
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	17%	29%	22%	40%	-14%	23%	-31%	-27%	-25%
Learning Disorders									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	135	387	121	263	283	195	108	197	167
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	12%	42%	-52%	100%	32%	-27%	75%	200%	-24%
FY19 ED Volume rate per 100,000 ages 0 - 17	103	496	88	94	147	97	108	0	73
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	84%	98%	-27%	150%	88%	33%	600%	-100%	-36%
Mental Health									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	772	881	581	619	1,417	438	1,065	1,312	1,304
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	-5%	0%	-20%	-39%	33%	-49%	-17%	156%	-3%
FY19 ED Volume rate per 100,000 ages 0 - 17	2,592	2,873	1,623	1,669	1,925	1,167	2,285	2,151	2,107
Change in ED Volume Rate FY17 to FY19 ages 0 - 17				56%					25%
Substance Use Disorders									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	53	44	11	19	49	0	46	26	63
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	-8%	-17%	0%	0%	67%	0%	-40%	100%	20%
FY19 ED Volume rate per 100,000 ages 0 - 17	343	373	88	169	313	170	139	157	438
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	-5%	31%	-11%	125%	88%	75%	-55%	-43%	133%
Complication of Medical Care									
FY19 Inpatient Discharges rate per 100,000 ages 0 - 17	229	613	274	150	215	292	139	105	209
Change in Inpatient Discharge Rate FY17 to FY19 ages 0 - 17	-4%	18%	-42%	-20%	-55%	-40%	29%	0%	11%
FY19 ED Volume rate per 100,000 ages 0 - 17	208	400	175	113	303	195	93	249	229
Change in ED Volume Rate FY17 to FY19 ages 0 - 17	3%	23%	14%	20%	41%	-38%	-25%	58%	-4%

Community Health Needs Assessment - Beth Israel Deaconess Medical Center

Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume
Patients aged 18-44, BIDMC Community Benefits Service Area defined by BILH Community Benefits
Boston includes zip codes 02111, 02115, 02118, 02119, 02120, 02121, 02122, 02124, 02125, 02134, 02135, 02163, 02215, Brookline includes zip codes 02445 and 02446

		BIDMC Community Benefits Service Area							
	MA	Boston	Brookline	Burlington	Chelsea	Chestnut Hill	Lexington	Needham	Peabody
All Cause									
FY19 Inpatient Discharges (all cause) rate per 100,000 ages 18-44	6,072	4,458	3,532	5,764	8,418	1,859	2,733	5,157	6,490
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	0%	3%	2%	-3%	2%	20%	-13%	1%	1%
FY19 ED Volume (all cause) rate per 100,000 ages 18-44	25,053	24,164	7,911	14,589	30,807	4,062	7,142	10,301	26,427
Change in ED Volume Rate FY17 to FY19 ages 18-44	-1%	6%	1%	-1%	-6%	1%	-10%	-12%	1%
Cancer									
Breast Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	32	26	9	22	80	8	31	61	46
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	-10%	-16%	-50%	-60%	500%	0%	0%	0%	300%
FY19 ED Volume rate per 100,000 ages 18-44	27	21	38	0	40	0	0	49	40
Change in ED Volume Rate FY17 to FY19 ages 18-44	25%	3%	80%	-100%	200%	-100%	-100%	300%	75%
Colorectal Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	15	9	13	11	20	8	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	17%	67%	-40%	-83%	200%	0%	-100%	0%	0%
FY19 ED Volume rate per 100,000 ages 18-44	4	8	13	0	0	0	0	0	0
Change in ED Volume Rate FY17 to FY19 ages 18-44	21%	550%	0%	0%	0%	0%	0%	0%	0%
GYN Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	41	32	34	22	140	72	21	12	40
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	11%	58%	167%	100%	24%	800%	100%	-50%	600%
FY19 ED Volume rate per 100,000 ages 18-44	30	23	4	0	27	0	0	0	23
Change in ED Volume Rate FY17 to FY19 ages 18-44	23%	19%	-67%	-100%	-43%	0%	0%	-100%	33%
Lung Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	26	20	34	22	66	56	0	12	40
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	3%	-18%	0%	0%	0%	133%	-100%	0%	40%
FY19 ED Volume rate per 100,000 ages 18-44	7	14	4	0	7	0	0	12	0
Change in ED Volume Rate FY17 to FY19 ages 18-44	47%	475%	0%	0%	-67%	0%	0%	0%	0%
Prostate Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	1	1	0	0	0	0	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	-15%	0%	0%	0%	0%	0%	-100%	0%	0%
FY19 ED Volume rate per 100,000 ages 18-44	0	1	0	0	0	0	0	0	0
Change in ED Volume Rate FY17 to FY19 ages 18-44	150%	0%	0%	0%	0%	0%	0%	0%	0%
Other Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	304	223	196	614	672	287	135	146	474
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	2%	-10%	21%	-5%	10%	38%	-19%	-40%	-12%
FY19 ED Volume rate per 100,000 ages 18-44	142	146	68	65	106	8	31	97	127
Change in ED Volume Rate FY17 to FY19 ages 18-44	29%	11%	0%	500%	-16%	-50%	-50%	14%	5%
Chronic Disease									
Asthma									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	745	704	320	679	924	88	321	510	954
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	-5%	4%	-25%	3%	-15%	-39%	15%	-5%	6%
FY19 ED Volume rate per 100,000 ages 18-44	2,649	2,718	771	1,218	3,730	407	590	1,262	2,909
Change in ED Volume Rate FY17 to FY19 ages 18-44	3%	19%	17%	-31%	-28%	34%	-30%	-4%	-4%
Congestive Heart Failure									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	124	173	34	22	299	0	21	49	58
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	14%	29%	300%	-80%	125%	-100%	-60%	100%	-9%

FY19 ED Volume rate per 100,000 ages 18-44	56	76	9	0	100	0	0	0	46
Change in ED Volume Rate FY17 to FY19 ages 18-44	42%	62%	100%	-100%	-17%	0%	0%	-100%	33%
COPD and Lung Disease									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	136	95	43	43	113	24	41	61	174
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	-5%	9%	100%	-33%	-23%	-25%	33%	67%	25%
FY19 ED Volume rate per 100,000 ages 18-44	127	80	9	43	40	0	52	12	69
Change in ED Volume Rate FY17 to FY19 ages 18-44	16%	17%	-50%	-33%	-54%	-100%	150%	0%	-40%
Diabetes Mellitus									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	478	449	119	560	858	16	135	376	405
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	5%	7%	-35%	13%	57%	-86%	18%	63%	37%
FY19 ED Volume rate per 100,000 ages 18-44	1,167	1,400	277	614	2,214	80	300	376	1,232
Change in ED Volume Rate FY17 to FY19 ages 18-44	7%	19%	2%	-25%	-2%	-17%	7%	29%	39%
Heart Disease									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	445	472	111	690	805	24	52	194	555
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	6%	17%	0%	83%	29%	-70%	-71%	14%	14%
FY19 ED Volume rate per 100,000 ages 18-44	375	392	170	172	366	112	104	182	440
Change in ED Volume Rate FY17 to FY19 ages 18-44	31%	60%	74%	7%	-2%	1300%	100%	-21%	33%
Hypertension									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	606	466	204	690	632	48	155	194	659
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	1%	-5%	33%	21%	-23%	20%	0%	0%	-14%
FY19 ED Volume rate per 100,000 ages 18-44	1,838	1,996	311	1,282	2,274	160	393	558	1,886
Change in ED Volume Rate FY17 to FY19 ages 18-44	8%	18%	18%	-1%	-19%	67%	0%	-18%	-9%
Liver Disease									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	427	284	136	388	1,057	24	124	206	463
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	15%	4%	-6%	-3%	-1%	-82%	0%	-23%	10%
FY19 ED Volume rate per 100,000 ages 18-44	185	116	17	22	213	0	41	85	168
Change in ED Volume Rate FY17 to FY19 ages 18-44	25%	32%	-20%	-67%	14%	0%	0%	75%	21%
Obesity									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	919	643	234	787	1,616	168	166	437	1,064
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	6%	-4%	-7%	35%	7%	91%	-43%	9%	6%
FY19 ED Volume rate per 100,000 ages 18-44	530	541	107	119	1,270	56	31	206	364
Change in ED Volume Rate FY17 to FY19 ages 18-44	11%	21%	9%	-66%	-26%	75%	-70%	6%	-49%
Stroke and Other Neurovascular Diseases									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	71	59	13	97	140	16	62	24	150
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	9%	41%	-73%	0%	91%	0%	20%	-67%	100%
FY19 ED Volume rate per 100,000 ages 18-44	28	16	0	43	40	0	0	12	17
Change in ED Volume Rate FY17 to FY19 ages 18-44	11%	24%	-100%	0%	50%	0%	-100%	-83%	0%
Injuries and Infections									
Allergy									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	553	443	204	593	432	168	176	328	746
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	13%	10%	-2%	28%	18%	31%	-6%	69%	47%
FY19 ED Volume rate per 100,000 ages 18-44	3,482	2,736	1,589	4,267	5,499	918	1,760	1,274	8,688
Change in ED Volume Rate FY17 to FY19 ages 18-44	44%	116%	147%	539%	-17%	188%	70%	38%	528%
Hepatitis									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	344	410	55	86	293	16	93	12	335
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	-4%	21%	-24%	-38%	-42%	-33%	80%	-50%	-31%
FY19 ED Volume rate per 100,000 ages 18-44	195	247	21	54	66	0	0	0	174
Change in ED Volume Rate FY17 to FY19 ages 18-44	1%	-22%	-64%	-38%	0%	-100%	-100%	-100%	-14%
HIV Infection									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	44	92	21	54	146	8	21	12	6
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	2%	34%	-17%	0%	47%	0%	0%	0%	-83%
FY19 ED Volume rate per 100,000 ages 18-44	102	284	21	54	113	0	0	0	75
Change in ED Volume Rate FY17 to FY19 ages 18-44	11%	37%	25%	400%	-11%	-100%	-100%	-100%	63%

Infections									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	1,534	1,454	677	1,218	2,048	407	476	570	1,834
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	2%	17%	-1%	-24%	7%	11%	-33%	-48%	16%
FY19 ED Volume rate per 100,000 ages 18-44	5,547	5,449	1,759	3,135	7,301	926	1,211	2,063	5,570
Change in ED Volume Rate FY17 to FY19 ages 18-44	-6%	-2%	-8%	11%	-17%	-9%	-30%	-10%	-4%
Injuries									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	1,103	1,067	435	1,077	1,549	168	445	437	1,232
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	5%	23%	-14%	-14%	25%	5%	-10%	-22%	33%
FY19 ED Volume rate per 100,000 ages 18-44 ages 18-44	7,762	8,430	2,722	4,461	9,296	1,349	2,474	3,603	6,877
Change in ED Volume Rate FY17 to FY19 ages 18-44	-4%	19%	0%	-5%	1%	-11%	1%	-14%	-18%
Poisonings									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	189	177	47	97	126	48	62	73	289
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	-7%	10%	-45%	-40%	-46%	20%	-45%	0%	43%
FY19 ED Volume rate per 100,000 ages 18-44	693	562	200	399	831	88	228	206	735
Change in ED Volume Rate FY17 to FY19 ages 18-44	-8%	1%	-31%	-23%	2%	-21%	0%	-11%	-19%
Pneumonia/Influenza									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	286	247	72	291	286	32	93	73	335
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	8%	24%	-23%	-4%	5%	33%	13%	-63%	16%
FY19 ED Volume rate per 100,000 ages 18-44	588	517	124	442	645	120	197	413	683
Change in ED Volume Rate FY17 to FY19 ages 18-44	27%	34%	-6%	37%	23%	88%	27%	62%	48%
Sexually Transmitted Diseases									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	80	79	21	108	120	24	10	24	81
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	-9%	-4%	0%	67%	-22%	200%	0%	-67%	17%
FY19 ED Volume rate per 100,000 ages 18-44	262	494	68	32	293	16	31	85	150
Change in ED Volume Rate FY17 to FY19 ages 18-44	15%	13%	-24%	-70%	2%	-60%	0%	75%	37%
Tuberculosis									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	9	20	0	54	20	0	0	0	6
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	-3%	88%	0%	400%	-40%	0%	-100%	0%	0%
FY19 ED Volume rate per 100,000 ages 18-44	5	12	0	0	20	0	0	0	12
Change in ED Volume Rate FY17 to FY19 ages 18-44	0%	46%	0%	0%	0%	0%	0%	0%	0%
Other									
Dementia and Cognitive Disorders									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	177	179	77	108	173	24	62	61	202
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	9%	46%	0%	-44%	-24%	0%	50%	-55%	13%
FY19 ED Volume rate per 100,000 ages 18-44	201	199	98	108	592	16	104	85	150
Change in ED Volume Rate FY17 to FY19 ages 18-44	-11%	-6%	77%	-9%	-26%	-60%	150%	40%	-28%
Mental Health									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	4,382	3,555	1,900	3,329	5,366	1,101	1,874	3,142	4,702
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	5%	17%	-4%	10%	18%	31%	13%	19%	9%
FY19 ED Volume rate per 100,000 ages 18-44	7,907	8,141	2,194	3,049	5,918	1,061	2,122	2,706	7,953
Change in ED Volume Rate FY17 to FY19 ages 18-44	16%	26%	-9%	-30%	-1%	-6%	-24%	-21%	8%
Parkinsons and Movement Disorders									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	41	39	34	43	80	32	21	0	52
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	-2%	7%	60%	33%	-8%	33%	100%	-100%	-25%
FY19 ED Volume rate per 100,000 ages 18-44	95	85	60	22	113	32	72	61	145
Change in ED Volume Rate FY17 to FY19 ages 18-44	-4%	-23%	133%	0%	13%	33%	250%	-17%	14%
Substance Use Disorders									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	2,012	1,621	366	1,465	2,075	192	424	485	2,007
Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	-2%	10%	-22%	26%	-10%	-20%	11%	-18%	-10%
FY19 ED Volume rate per 100,000 ages 18-44	8,347	8,392	1,512	3,847	11,031	774	1,708	1,080	9,139
Change in ED Volume Rate FY17 to FY19 ages 18-44	0%	12%	8%	-21%	-3%	3%	1%	-51%	-15%
Complication of Medical Care									
FY19 Inpatient Discharges rate per 100,000 ages 18-44	2,698	1,796	2,241	2,758	4,123	1,165	1,501	3,264	3,152

Change in Inpatient Discharge Rate FY17 to FY19 ages 18-44	5%	4%	5%	-13%	-1%	28%	-16%	10%	0%
FY19 ED Volume rate per 100,000 ages 18-44	582	522	213	550	878	80	155	231	787
Change in ED Volume Rate FY17 to FY19 ages 18-44	14%	30%	0%	104%	25%	-9%	-6%	-55%	48%

Community Health Needs Assessment - Beth Israel Deaconess Medical Center

Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume

Patients aged 45-64, BIDMC Community Benefits Service Area defined by BILH Community Benefits

Boston includes zip codes 02111, 02115, 02118, 02119, 02120, 02121, 02122, 02124, 02125, 02134, 02135, 02163, 02215, Brookline includes zip codes 02445 and 02446

		BIDMC Community Benefits Service Area							
	MA	Boston	Brookline	Burlington	Chelsea	Chestnut Hill	Lexington	Needham	Peabody
All Cause									
FY19 Inpatient Discharges (all cause) rate per 100,000 ages 45-64	9,762	11,751	5,007	9,212	9,656	3,882	4,037	5,138	10,017
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	0%	-4%	0%	-7%	3%	-2%	-18%	-2%	-7%
FY19 ED Volume (all cause) rate per 100,000 ages 45-64	24,003	44,361	10,421	15,977	30,121	7,382	7,970	10,336	24,338
Change in ED Volume Rate FY17 to FY19 ages 45-64	2%	4%	6%	-5%	-4%	-1%	-4%	-17%	4%
Cancer									
Breast Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	258	245	253	253	270	297	249	460	264
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	-5%	-1%	56%	-25%	117%	-13%	33%	39%	-11%
FY19 ED Volume rate per 100,000 ages 45-64	195	346	136	127	52	233	42	259	237
Change in ED Volume Rate FY17 to FY19 ages 45-64	18%	15%	-35%	80%	25%	83%	-50%	0%	75%
Colorectal Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	116	121	127	28	187	64	62	71	149
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	0%	-3%	250%	-86%	64%	-25%	-40%	-45%	29%
FY19 ED Volume rate per 100,000 ages 45-64	27	56	18	0	42	21	21	0	20
Change in ED Volume Rate FY17 to FY19 ages 45-64	12%	68%	100%	0%	100%	0%	0%	-100%	200%
GYN Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	182	210	136	225	177	42	62	189	237
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	-3%	2%	0%	0%	-35%	-33%	-57%	-16%	-10%
FY19 ED Volume rate per 100,000 ages 45-64	82	122	117	56	52	0	31	94	47
Change in ED Volume Rate FY17 to FY19 ages 45-64	21%	17%	333%	33%	-29%	-100%	0%	-11%	-22%
Lung Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	358	428	217	309	270	191	62	271	325
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	5%	10%	-20%	69%	-28%	-44%	-83%	-12%	-32%
FY19 ED Volume rate per 100,000 ages 45-64	97	128	9	42	31	21	10	82	74
Change in ED Volume Rate FY17 to FY19 ages 45-64	21%	18%	-75%	200%	-63%	-67%	-67%	17%	-45%
Prostate Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	133	163	81	127	42	85	0	106	203
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	-5%	-15%	200%	-59%	-56%	-43%	-100%	-31%	3%
FY19 ED Volume rate per 100,000 ages 45-64	60	133	18	28	52	0	0	141	14
Change in ED Volume Rate FY17 to FY19 ages 45-64	30%	95%	0%	-50%	400%	-100%	0%	71%	-71%
Other Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	1,984	2,107	1,491	1,857	1,589	1,485	1,048	1,674	2,227
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	3%	-4%	-11%	-20%	1%	-24%	-63%	-11%	-18%
FY19 ED Volume rate per 100,000 ages 45-64	597	780	371	408	228	318	176	566	528
Change in ED Volume Rate FY17 to FY19 ages 45-64	27%	7%	-25%	4%	-15%	15%	-15%	-16%	4%
Chronic Disease									
Asthma									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	1,051	1,741	497	999	1,339	509	353	577	1,313
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	-17%	-11%	-17%	13%	-19%	-4%	-19%	17%	-4%
FY19 ED Volume rate per 100,000 ages 45-64	1,944	3,756	795	1,406	4,153	403	477	884	2,234
Change in ED Volume Rate FY17 to FY19 ages 45-64	0%	8%	49%	-24%	0%	-49%	-29%	-23%	3%
Congestive Heart Failure									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	1,292	2,056	461	1,139	1,402	339	384	483	1,232
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	10%	-6%	0%	16%	-15%	-11%	12%	24%	-12%

FY19 ED Volume rate per 100,000 ages 45-64	396	927	81	239	446	0	104	189	514
Change in ED Volume Rate FY17 to FY19 ages 45-64	41%	28%	-25%	-6%	16%	-100%	100%	-20%	81%
COPD and Lung Disease									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	1,994	2,159	606	914	1,703	127	322	695	1,685
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	1%	-2%	40%	-23%	-2%	-40%	-37%	5%	-29%
FY19 ED Volume rate per 100,000 ages 45-64	1,388	2,040	298	549	2,720	42	83	271	1,387
Change in ED Volume Rate FY17 to FY19 ages 45-64	10%	12%	27%	-17%	22%	-33%	-20%	-43%	-6%
Diabetes Mellitus									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	2,808	3,911	1,482	2,419	3,686	1,039	706	1,155	2,856
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	3%	-8%	22%	2%	5%	17%	-19%	17%	-4%
FY19 ED Volume rate per 100,000 ages 45-64	4,109	8,926	1,943	2,039	7,081	679	913	1,308	3,959
Change in ED Volume Rate FY17 to FY19 ages 45-64	10%	10%	24%	-29%	-6%	-3%	-25%	-4%	2%
Heart Disease									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	3,609	4,815	1,446	4,416	4,631	1,315	1,359	1,626	3,838
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	4%	-1%	-14%	4%	3%	19%	25%	6%	6%
FY19 ED Volume rate per 100,000 ages 45-64	1,448	2,287	660	731	1,962	827	425	660	1,624
Change in ED Volume Rate FY17 to FY19 ages 45-64	17%	23%	24%	-33%	-7%	22%	-23%	-33%	3%
Hypertension									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	4,045	4,826	1,826	3,882	3,914	1,379	1,380	1,662	4,298
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	-2%	-3%	4%	-7%	9%	14%	-23%	-7%	-12%
FY19 ED Volume rate per 100,000 ages 45-64	7,878	17,194	3,055	4,698	11,048	2,185	1,671	3,288	8,298
Change in ED Volume Rate FY17 to FY19 ages 45-64	10%	20%	6%	-29%	-8%	3%	-25%	-14%	0%
Liver Disease									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	1,562	1,932	868	1,617	2,388	382	394	860	1,672
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	5%	-10%	28%	22%	35%	20%	-39%	83%	2%
FY19 ED Volume rate per 100,000 ages 45-64	404	670	181	127	343	42	83	130	420
Change in ED Volume Rate FY17 to FY19 ages 45-64	19%	34%	233%	-40%	83%	-50%	-20%	10%	38%
Obesity									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	2,410	2,476	786	1,899	2,180	997	467	919	2,714
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	5%	-11%	-10%	21%	-5%	18%	-35%	18%	-8%
FY19 ED Volume rate per 100,000 ages 45-64	675	1,290	271	309	1,599	148	83	330	474
Change in ED Volume Rate FY17 to FY19 ages 45-64	17%	55%	30%	-24%	19%	-36%	-38%	115%	-49%
Stroke and Other Neurovascular Diseases									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	443	549	253	886	457	127	270	247	508
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	2%	5%	-13%	58%	-15%	-45%	0%	-5%	1%
FY19 ED Volume rate per 100,000 ages 45-64	119	115	27	42	145	21	73	71	162
Change in ED Volume Rate FY17 to FY19 ages 45-64	6%	-12%	-50%	0%	56%	-75%	250%	-57%	26%
Injuries and Infections									
Allergy									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	1,314	1,813	705	1,041	1,173	615	560	471	1,685
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	20%	11%	30%	-10%	61%	61%	80%	33%	63%
FY19 ED Volume rate per 100,000 ages 45-64	4,000	5,067	3,154	5,612	6,541	2,058	2,594	1,226	10,200
Change in ED Volume Rate FY17 to FY19 ages 45-64	59%	197%	693%	625%	-14%	194%	136%	93%	802%
Hepatitis									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	492	1,556	280	197	737	127	135	59	338
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	-19%	-16%	-14%	-44%	-37%	-25%	-59%	-69%	-31%
FY19 ED Volume rate per 100,000 ages 45-64	211	591	18	84	73	0	21	0	95
Change in ED Volume Rate FY17 to FY19 ages 45-64	-11%	-52%	-75%	50%	-50%	0%	0%	-100%	-22%
HIV Infection									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	157	741	45	42	197	21	83	35	54
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	-7%	-8%	-58%	-25%	0%	0%	0%	200%	-65%
FY19 ED Volume rate per 100,000 ages 45-64	236	1,535	99	28	239	0	21	12	122
Change in ED Volume Rate FY17 to FY19 ages 45-64	-3%	-4%	-48%	-50%	-26%	0%	-33%	-50%	80%

Infections									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	3,824	5,004	2,025	3,727	4,288	1,209	1,743	2,381	4,027
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	3%	-5%	-5%	-20%	9%	2%	-21%	0%	-9%
FY19 ED Volume rate per 100,000 ages 45-64	3,618	5,618	1,618	2,180	4,662	1,252	1,152	1,249	3,269
Change in ED Volume Rate FY17 to FY19 ages 45-64	-4%	-6%	-1%	-15%	-3%	55%	-17%	-36%	-10%
Injuries									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	3,425	4,511	1,790	3,516	3,582	1,336	1,443	1,567	4,034
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	6%	13%	-2%	5%	16%	-21%	-32%	-1%	1%
FY19 ED Volume rate per 100,000 ages 45-64	7,959	15,059	4,329	5,134	7,953	2,185	3,342	4,160	8,332
Change in ED Volume Rate FY17 to FY19 ages 45-64	-2%	20%	16%	3%	0%	-30%	8%	-24%	2%
Poisonings									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	232	390	145	211	228	64	52	71	298
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	-7%	-6%	0%	15%	-12%	-50%	0%	-40%	52%
FY19 ED Volume rate per 100,000 ages 45-64	395	671	145	183	249	21	93	153	386
Change in ED Volume Rate FY17 to FY19 ages 45-64	5%	-13%	-33%	-43%	-43%	-83%	80%	18%	21%
Pneumonia/Influenza									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	1,135	1,383	389	1,308	1,038	318	384	589	1,157
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	8%	7%	-9%	33%	4%	-35%	-30%	2%	-8%
FY19 ED Volume rate per 100,000 ages 45-64	555	888	271	506	498	212	228	236	569
Change in ED Volume Rate FY17 to FY19 ages 45-64	11%	13%	43%	57%	-4%	100%	-4%	-33%	8%
Sexually Transmitted Diseases									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	24	65	0	0	10	21	10	0	14
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	-3%	-10%	-100%	-100%	-80%	0%	-50%	-100%	-80%
FY19 ED Volume rate per 100,000 ages 45-64	38	170	9	14	31	21	31	12	20
Change in ED Volume Rate FY17 to FY19 ages 45-64	5%	5%	0%	0%	-40%	0%	0%	0%	-40%
Tuberculosis									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	18	54	0	0	21	21	10	0	20
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	-3%	-23%	0%	-100%	-33%	0%	0%	0%	0%
FY19 ED Volume rate per 100,000 ages 45-64	6	31	0	0	0	0	10	0	0
Change in ED Volume Rate FY17 to FY19 ages 45-64	7%	50%	0%	0%	-100%	0%	0%	0%	0%
Other									
Dementia and Cognitive Disorders									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	868	1,145	515	802	1,007	127	291	471	1,198
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	10%	-4%	8%	21%	10%	-45%	-22%	-7%	44%
FY19 ED Volume rate per 100,000 ages 45-64	325	614	181	98	872	106	114	177	257
Change in ED Volume Rate FY17 to FY19 ages 45-64	-5%	-2%	11%	-30%	-43%	150%	-39%	7%	65%
Mental Health									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	7,268	9,559	4,537	5,232	8,047	2,821	2,667	3,512	8,203
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	4%	8%	-2%	-10%	6%	14%	0%	12%	9%
FY19 ED Volume rate per 100,000 ages 45-64	6,209	12,608	3,543	2,644	4,818	1,549	1,266	1,591	6,721
Change in ED Volume Rate FY17 to FY19 ages 45-64	17%	20%	14%	-28%	3%	-20%	-7%	-46%	11%
Parkinsons and Movement Disorders									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	252	397	127	323	228	42	156	177	223
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	8%	29%	-18%	-12%	0%	-67%	-32%	200%	-23%
FY19 ED Volume rate per 100,000 ages 45-64	185	313	181	155	239	64	42	47	88
Change in ED Volume Rate FY17 to FY19 ages 45-64	5%	-28%	150%	10%	-21%	0%	-43%	0%	-24%
Substance Use Disorders									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	3,820	5,904	1,564	2,433	3,946	636	612	1,072	3,736
Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	0%	-1%	7%	-21%	-1%	15%	-39%	8%	0%
FY19 ED Volume rate per 100,000 ages 45-64	7,619	21,129	2,043	3,910	12,200	870	716	955	7,350
Change in ED Volume Rate FY17 to FY19 ages 45-64	3%	13%	21%	-3%	-6%	-5%	-41%	-43%	-9%
Complication of Medical Care									
FY19 Inpatient Discharges rate per 100,000 ages 45-64	1,870	2,324	1,247	2,068	1,973	785	664	1,167	2,254

Change in Inpatient Discharge Rate FY17 to FY19 ages 45-64	7%	3%	33%	11%	19%	-8%	-36%	2%	6%
FY19 ED Volume rate per 100,000 ages 45-64	472	918	226	492	768	85	208	295	657
Change in ED Volume Rate FY17 to FY19 ages 45-64	8%	12%	-7%	-3%	131%	33%	-9%	-40%	106%

Community Health Needs Assessment - Beth Israel Deaconess Medical Center

Source: Center for Health Information and Analysis (CHIA) Massachusetts Inpatient Discharges and Emergency Department Volume

Patients aged 65+, BIDMC Community Benefits Service Area defined by BILH Community Benefits

Boston includes zip codes 02111, 02115, 02118, 02119, 02120, 02121, 02122, 02124, 02125, 02134, 02135, 02163, 02215, Brookline includes zip codes 02445 and 02446

		BIDMC Community Benefits Service Area							
	MA	Boston	Brookline	Burlington	Chelsea	Chestnut Hill	Lexington	Needham	Peabody
All Cause									
FY19 Inpatient Discharges (all cause) rate per 100,000 ages 65+	25,473	24,152	21,785	30,977	30,507	18,071	18,078	24,588	28,055
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	5%	4%	10%	-6%	-9%	6%	11%	1%	-4%
FY19 ED Volume (all cause) rate per 100,000 ages 65+	26,010	33,969	19,836	26,062	36,214	18,542	15,486	27,485	27,079
Change in ED Volume Rate FY17 to FY19 ages 65+	10%	16%	12%	0%	5%	29%	3%	-1%	0%
Cancer									
Breast Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 65+	1,253	1,114	1,591	1,762	733	1,710	951	1,448	1,636
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	6%	2%	3%	-8%	-33%	60%	-22%	-4%	17%
FY19 ED Volume rate per 100,000 ages 65+	480	551	650	235	183	793	169	766	428
Change in ED Volume Rate FY17 to FY19 ages 65+	42%	31%	40%	0%	-27%	19%	-24%	-18%	6%
Colorectal Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 65+	271	256	119	529	344	74	234	200	278
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	2%	23%	-25%	108%	15%	-73%	80%	33%	37%
FY19 ED Volume rate per 100,000 ages 65+	42	33	40	20	69	0	13	17	8
Change in ED Volume Rate FY17 to FY19 ages 65+	9%	10%	0%	0%	-67%	-100%	0%	-75%	-75%
GYN Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 65+	508	436	305	587	642	347	221	366	698
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	6%	-18%	-23%	-12%	-13%	-60%	-26%	29%	9%
FY19 ED Volume rate per 100,000 ages 65+	145	156	66	98	69	124	26	150	113
Change in ED Volume Rate FY17 to FY19 ages 65+	47%	-32%	25%	0%	-25%	-62%	0%	-25%	15%
Lung Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 65+	1,347	1,321	1,021	1,508	1,375	1,116	625	1,315	1,276
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	9%	22%	33%	-4%	-31%	18%	14%	3%	12%
FY19 ED Volume rate per 100,000 ages 65+	282	346	172	98	275	124	91	400	293
Change in ED Volume Rate FY17 to FY19 ages 65+	26%	51%	44%	-44%	-8%	-17%	-13%	14%	34%
Prostate Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 65+	1,270	1,378	1,299	1,899	1,215	1,958	1,276	2,031	1,546
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	6%	8%	-9%	5%	-16%	14%	46%	1%	8%
FY19 ED Volume rate per 100,000 ages 65+	434	749	517	98	275	818	287	666	315
Change in ED Volume Rate FY17 to FY19 ages 65+	36%	7%	77%	-38%	140%	43%	57%	-33%	14%
Other Cancer									
FY19 Inpatient Discharges rate per 100,000 ages 65+	7,146	6,323	8,645	10,202	7,541	8,577	6,030	9,389	9,554
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	13%	9%	12%	11%	-2%	15%	11%	15%	10%
FY19 ED Volume rate per 100,000 ages 65+	1,519	1,493	1,631	822	894	2,405	755	2,647	1,696
Change in ED Volume Rate FY17 to FY19 ages 65+	33%	3%	29%	27%	-11%	1%	71%	-6%	38%
Chronic Disease									
Asthma									
FY19 Inpatient Discharges rate per 100,000 ages 65+	1,596	2,224	1,724	2,036	2,063	1,686	1,276	1,815	2,424
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	-16%	-10%	-20%	-5%	-38%	1%	3%	11%	-18%
FY19 ED Volume rate per 100,000 ages 65+	1,257	2,116	1,246	1,175	3,828	1,289	794	1,365	1,486
Change in ED Volume Rate FY17 to FY19 ages 65+	8%	9%	45%	-19%	4%	13%	-9%	1%	-7%
Congestive Heart Failure									
FY19 Inpatient Discharges rate per 100,000 ages 65+	8,161	8,364	6,828	9,908	11,208	5,454	5,262	7,808	9,899
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	9%	4%	13%	-2%	-7%	17%	26%	-5%	-2%

FY19 ED Volume rate per 100,000 ages 65+	1,705	2,278	1,008	2,624	3,048	1,438	860	2,231	2,657
Change in ED Volume Rate FY17 to FY19 ages 65+	34%	41%	46%	9%	60%	107%	-15%	-6%	28%
COPD and Lung Disease									
FY19 Inpatient Discharges rate per 100,000 ages 65+	7,130	5,607	3,792	7,186	9,993	3,198	3,126	4,345	7,648
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	5%	6%	9%	-13%	-13%	15%	35%	-21%	-2%
FY19 ED Volume rate per 100,000 ages 65+	2,422	2,510	955	1,508	4,515	1,190	664	1,931	2,237
Change in ED Volume Rate FY17 to FY19 ages 65+	18%	37%	16%	-44%	16%	118%	-4%	-9%	-13%
Diabetes Mellitus									
FY19 Inpatient Discharges rate per 100,000 ages 65+	8,376	10,121	5,834	9,771	13,523	4,065	4,585	5,693	9,479
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	5%	3%	14%	-7%	-2%	12%	35%	8%	5%
FY19 ED Volume rate per 100,000 ages 65+	5,867	10,630	4,018	5,678	11,643	2,578	2,175	4,412	6,357
Change in ED Volume Rate FY17 to FY19 ages 65+	18%	22%	48%	-13%	-4%	24%	-25%	3%	2%
Heart Disease									
FY19 Inpatient Discharges rate per 100,000 ages 65+	18,344	17,004	15,049	23,458	25,395	14,303	13,298	18,695	24,092
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	6%	4%	10%	-9%	-8%	13%	28%	-1%	5%
FY19 ED Volume rate per 100,000 ages 65+	3,975	4,544	3,368	3,779	5,088	4,338	1,732	5,044	5,119
Change in ED Volume Rate FY17 to FY19 ages 65+	16%	29%	33%	-41%	-1%	48%	-39%	-20%	-15%
Hypertension									
FY19 Inpatient Discharges rate per 100,000 ages 65+	10,397	9,432	7,982	12,434	11,529	7,288	7,137	9,472	10,665
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	-1%	0%	2%	-17%	-10%	-4%	9%	-2%	-9%
FY19 ED Volume rate per 100,000 ages 65+	12,665	18,265	9,215	11,670	16,915	9,246	6,747	14,999	12,571
Change in ED Volume Rate FY17 to FY19 ages 65+	14%	20%	12%	-19%	-12%	30%	-11%	1%	-11%
Liver Disease									
FY19 Inpatient Discharges rate per 100,000 ages 65+	1,956	2,369	1,525	2,056	2,934	917	990	2,264	1,884
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	16%	11%	21%	-1%	-5%	-10%	23%	70%	-10%
FY19 ED Volume rate per 100,000 ages 65+	258	346	40	176	298	50	104	200	158
Change in ED Volume Rate FY17 to FY19 ages 65+	36%	67%	-70%	800%	0%	0%	300%	9%	0%
Obesity									
FY19 Inpatient Discharges rate per 100,000 ages 65+	3,869	3,672	2,029	3,015	4,813	1,264	1,446	2,297	4,301
Change in Inpatient Discharge Rate FY17 to FY19	14%	2%	0%	-7%	11%	-25%	39%	31%	17%
FY19 ED Volume rate per 100,000	367	587	225	196	894	248	39	216	128
Change in ED Volume Rate FY17 to FY19	26%	55%	70%	-63%	-43%	11%	-25%	117%	-70%
Stroke and Other Neurovascular Diseases									
FY19 Inpatient Discharges rate per 100,000	2,064	2,260	1,870	2,996	2,521	1,487	1,641	1,864	2,071
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	5%	17%	18%	0%	-4%	46%	17%	-8%	2%
FY19 ED Volume rate per 100,000 ages 65+	380	307	252	59	298	223	169	466	293
Change in ED Volume Rate FY17 to FY19 ages 65+	10%	-9%	46%	-50%	-41%	13%	-19%	-47%	-19%
Injuries and Infections									
Allergy									
FY19 Inpatient Discharges rate per 100,000 ages 65+	3,711	3,377	3,275	4,367	4,217	3,619	2,826	2,397	5,884
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	32%	18%	59%	32%	74%	68%	48%	100%	99%
FY19 ED Volume rate per 100,000 ages 65+	5,138	4,346	5,436	10,574	7,587	6,346	6,304	2,880	13,112
Change in ED Volume Rate FY17 to FY19 ages 65+	88%	321%	832%	2060%	-8%	341%	186%	184%	1908%
Hepatitis									
FY19 Inpatient Discharges rate per 100,000 ages 65+	273	930	292	137	733	174	195	133	158
Change in Inpatient Discharge Rate FY17 to FY19v	-3%	-4%	0%	-13%	-6%	0%	150%	-27%	11%
FY19 ED Volume rate per 100,000 ages 65+	70	193	66	20	0	25	0	0	45
Change in ED Volume Rate FY17 to FY19 ages 65+	36%	-39%	25%	0%	-100%	0%	0%	-100%	0%
HIV Infection									
FY19 Inpatient Discharges rate per 100,000 ages 65+	53	211	13	39	138	25	0	0	0
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	2%	-7%	-75%	0%	-45%	0%	0%	-100%	-100%
FY19 ED Volume rate per 100,000 ages 65+	47	241	0	0	481	0	0	83	0
Change in ED Volume Rate FY17 to FY19 ages 65+	34%	-16%	0%	0%	320%	0%	0%	67%	-100%

Infections									
FY19 Inpatient Discharges rate per 100,000 ages 65+	12,591	12,628	11,098	16,311	15,723	8,775	9,169	13,418	14,222
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	6%	9%	2%	-6%	-13%	12%	8%	-10%	0%
FY19 ED Volume rate per 100,000 ages 65+	4,213	4,833	3,381	4,073	5,455	3,297	2,344	3,762	3,940
Change in ED Volume Rate FY17 to FY19 ages 65+	3%	2%	30%	18%	-4%	39%	10%	-14%	1%
Injuries									
FY19 Inpatient Discharges rate per 100,000 ages 65+	11,877	12,147	12,875	15,782	16,411	11,849	10,485	12,502	16,684
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	15%	21%	14%	-7%	14%	6%	22%	-1%	6%
FY19 ED Volume rate per 100,000 ages 65+	10,393	12,968	8,101	11,005	10,268	8,726	6,760	13,235	11,318
Change in ED Volume Rate FY17 to FY19 ages 65+	11%	28%	7%	10%	2%	39%	6%	-13%	-7%
Poisonings									
FY19 Inpatient Discharges rate per 100,000 ages 65+	281	277	292	411	298	248	104	133	263
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	7%	11%	16%	62%	-24%	100%	-20%	-11%	-24%
FY19 ED Volume rate per 100,000 ages 65+	185	184	133	274	252	149	182	117	143
Change in ED Volume Rate FY17 to FY19 ages 65+	27%	27%	43%	133%	10%	-14%	40%	-22%	-5%
Pneumonia/Influenza									
FY19 Inpatient Discharges rate per 100,000 ages 65+	4,188	3,332	3,036	5,346	5,615	2,851	2,800	4,645	4,571
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	0%	-4%	-6%	-8%	-8%	34%	21%	-13%	-9%
FY19 ED Volume rate per 100,000 ages 65+	569	686	451	568	825	471	300	566	585
Change in ED Volume Rate FY17 to FY19 ages 65+	1%	18%	26%	-24%	-22%	12%	-26%	10%	-16%
Sexually Transmitted Diseases									
FY19 Inpatient Discharges rate per 100,000 ages 65+	30	66	40	20	0	0	39	17	23
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	9%	-27%	-25%	0%	-100%	-100%	200%	0%	50%
FY19 ED Volume rate per 100,000 ages 65+	5	24	0	0	0	0	0	0	8
Change in ED Volume Rate FY17 to FY19 ages 65+	0%	0%	0%	0%	-100%	0%	0%	0%	0%
Tuberculosis									
FY19 Inpatient Discharges rate per 100,000 ages 65+	52	184	13	157	69	50	91	17	15
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	-11%	7%	-88%	60%	-25%	0%	0%	-75%	-33%
FY19 ED Volume rate per 100,000 ages 65+	6	24	0	20	23	0	13	0	0
Change in ED Volume Rate FY17 to FY19 ages 65+	13%	-33%	0%	-67%	0%	0%	0%	-100%	0%
Other									
Dementia and Cognitive Disorders									
FY19 Inpatient Discharges rate per 100,000 ages 65+	6,264	6,811	6,881	7,950	9,374	4,983	5,014	7,158	7,258
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	6%	11%	36%	2%	-13%	14%	20%	-7%	-4%
FY19 ED Volume rate per 100,000 ages 65+	2,053	2,041	1,392	1,488	2,567	793	1,029	3,629	1,981
Change in ED Volume Rate FY17 to FY19 ages 65+	11%	33%	3%	-36%	-15%	-3%	-16%	-13%	-15%
Mental Health									
FY19 Inpatient Discharges rate per 100,000 ages 65+	10,900	9,772	11,363	12,688	18,840	9,098	6,747	9,772	14,830
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	15%	20%	19%	8%	20%	20%	25%	-3%	28%
FY19 ED Volume rate per 100,000 ages 65+	3,500	4,274	3,872	2,252	4,928	2,702	1,042	2,331	4,278
Change in ED Volume Rate FY17 to FY19 ages 65+	35%	24%	80%	-32%	101%	38%	-34%	-16%	41%
Parkinsons and Movement Disorders									
FY19 Inpatient Discharges rate per 100,000 ages 65+	1,523	1,375	1,591	2,115	1,513	1,140	1,289	1,931	1,989
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	10%	16%	-1%	-11%	-15%	2%	11%	21%	0%
FY19 ED Volume rate per 100,000 ages 65+	602	569	477	470	688	793	391	899	510
Change in ED Volume Rate FY17 to FY19 ages 65+	11%	20%	-10%	-43%	67%	113%	-6%	20%	-39%
Substance Use Disorders									
FY19 Inpatient Discharges rate per 100,000 ages 65+	2,956	3,651	1,737	2,683	4,928	843	821	1,165	2,454
Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	13%	13%	20%	-3%	17%	-26%	40%	-13%	4%
FY19 ED Volume rate per 100,000 ages 65+	2,258	5,336	835	901	4,446	421	547	383	1,921
Change in ED Volume Rate FY17 to FY19 ages 65+	22%	42%	37%	-34%	13%	0%	14%	-41%	3%
Complication of Medical Care									
FY19 Inpatient Discharges rate per 100,000 ages 65+	4,867	5,198	5,158	6,423	5,776	3,966	3,608	5,177	6,229

Change in Inpatient Discharge Rate FY17 to FY19 ages 65+	13%	13%	10%	21%	-9%	-5%	9%	3%	25%
FY19 ED Volume rate per 100,000 ages 65+	835	1,162	544	1,273	1,788	942	521	1,032	811
Change in ED Volume Rate FY17 to FY19 ages 65+	9%	5%	-21%	-4%	28%	73%	5%	-19%	2%

Notes:

Population counts: Sg2 Claritas Demographic Data, 2021.

Data is broken out into four age groupings (0-17, 18-44, 45-64, 65+). One age group per tab.

Included data is a calculated rate of inpatient discharge or ED volume per 100,000 population, by town. Inpatient discharge and ED data retrieved from CHIA FY17 and FY19.

Categorization of the Health Conditions listed above determined by Sg2 CARE Family (ICD-9 and -10 diagnosis code to disease grouping)

Percent change based on rate per 100,000 in FY17 compared to rate per 100,000 in FY19, using identical Sg2 CARE Family definitions. Please note the % change in rate for some health conditions is large, likely due to small volumes or coding changes.

Volumes noted as <11 are supressed per CHIA cell suppression guidelines.

BILH Community Health Survey

*Note: BIDMC did not administer this survey due to other survey efforts in the region (e.g., Boston CHNA-CHIP Collaborative).

- Survey (used for BID Needham and LHMC)
- Survey Marketing Plan/Distribution Channels

Beth Israel Lahey Health

Community Health Survey for Beth Israel Lahey Health
2022 Community Health Needs Assessment

Beth Israel Lahey Health and its member hospitals are conducting a Community Health Needs Assessment to better understand the most pressing health-related issues for residents in the communities we serve. It is important that each hospital gather input from people living, working, and learning in the community. The information gathered will help each hospital to improve its patient and community services.

Please take about 15 minutes to complete this survey. Your responses will be private. If you do not feel comfortable answering a question, you may skip it. Taking this survey will not affect any services that you receive. Findings from this survey that are shared back with the community will be combined across all respondents. It will not be possible to identify you or your responses. Thank you for completing this survey.

You will have the option at the end of the survey to enter a drawing for a $100 gift card

We have shared this survey widely. Please complete this survey only once.

Time in Community

1. We are interested in your experiences in the community where you spend the most time. This may be the place where you live, work, play, or learn.
   Please enter the zip code of the community in which you spend the most time.
   Zip code: _____

1. How many years have you lived in the selected community?
   - ❑ Less than 1 year
   - ❑ 1-5 years
   - ❑ 6-10 years
   - ❑ Over 10 years but not all my life
   - ❑ I have lived here all my life
   - ❑ I used to live here, but not anymore
   - ❑ I have never lived here

2. How many years have you worked in the selected community?
   - ❑ Less than 1 year
   - ❑ 1-5 years
   - ❑ 6-10 years
   - ❑ Over 10 years
   - ❑ I do not work here

3. If you do not live or work in the selected community, how are you connected to it?
   _____

Your Community

4. Please check the response that best describes how much you agree or disagree with each statement about your community.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know
I feel like I belong in my community.	☐	☐	☐	☐	☐
Overall, I am satisfied with the quality of life in my community. (Think about things like health care, raising children, getting older, job opportunities, safety, and support.)	☐	☐	☐	☐	☐
My community is a good place to raise children. (Think about things like schools, day care, after school programs, housing, and places to play)	☐	☐	☐	☐	☐
My community is a good place to grow old. (Think about things like housing, transportation, houses of worship, shopping, health care, and social support)	☐	☐	☐	☐	☐
My community has good access to resources. (Think about organizations, agencies, healthcare, etc.).	☐	☐	☐	☐	☐

5. What are the most important things you would like to improve about your community? Please select up to 5 items from the list below.

- ☐ Better access to good jobs
- ☐ Better access to health care
- ☐ Better access to healthy food
- ☐ Better access to internet
- ☐ Better access to public transportation
- ☐ Better parks and recreation
- ☐ Better roads
- ☐ Better schools
- ☐ Better sidewalks and trails Cleaner environment
- ☐ Lower crime and violence
- ☐ More affordable childcare
- ☐ More affordable housing
- ☐ More arts and cultural events
- ☐ More effective city services (like water, trash, fire department, and police)
- ☐ More inclusion for diverse members of the community
- ☐ Stronger community leadership
- ☐ Stronger sense of community
- ☐ Other (_____)

Social + Cultural Environment

6. We are interested to know about your experiences finding support in your community. For each of the statements below, please check the response that best describes how much you agree or disagree with each statement.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know
There are people and/or organizations in my community that support me during times of stress and need.	☐	☐	☐	☐	☐
I believe that all residents, including myself, can make the community a better place to live.	☐	☐	☐	☐	☐
During COVID-19, information I need to stay healthy and safe has been readily available in my community.	☐	☐	☐	☐	☐
During COVID-19, resources I need to stay healthy and safe have been readily available in my community.	☐	☐	☐	☐	☐

Natural + Built Environment

7. The natural and built environment impacts the health and wellbeing of people and communities. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat true	Not at all true	I don't know
My community feels safe.	☐	☐	☐	☐
People like me have access to safe, clean parks and open spaces.	☐	☐	☐	☐
People like me have access to reliable transportation.	☐	☐	☐	☐
People like me have housing that is safe and good quality.	☐	☐	☐	☐
The air in my community is healthy to breathe.	☐	☐	☐	☐
The water in my community is safe to drink.	☐	☐	☐	☐
My community is prepared to protect ourselves during climate disasters, such as flooding, hurricanes, or blizzards.	☐	☐	☐	☐
During extreme heat, people like me have access to options for staying cool.	☐	☐	☐	☐

Economic + Educational Environment

8. The economic and educational environment impacts the health and wellbeing of people and communities. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat true	Not at all true	I don't know
People like me have access to good local jobs with living wages and benefits.	☐	☐	☐	☐
People like me have access to local investment opportunities, such as owning homes or businesses.	☐	☐	☐	☐
Housing in my community is affordable for people with different income levels.	☐	☐	☐	☐
People like me have access to affordable childcare services.	☐	☐	☐	☐
People like me have access to good education for their children.	☐	☐	☐	☐

9. How much do you agree or disagree with the statements below?

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
The built, economic, and educational environments in my community are impacted by **systemic racism**. This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose.	☐	☐	☐	☐	☐
The built, economic, and educational environments in my community are impacted by **individual racism**. This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly.	☐	☐	☐	☐	☐

Health + Access to care

10. The healthcare environment impacts the health and wellbeing of people and communities. For each statement below, check the response that best describes how true you think the statement is.

	True	Somewhat true	Not at all true	I don't know
Health care in my community meets the physical health needs of people like me.	☐	☐	☐	☐
Health care in my community meets the mental health needs of people like me.	☐	☐	☐	☐

11. In the last 12 months, did you ever need any of the following types of health care? Please check the response that best describes your experience.

	I needed this type of care and was able to access it.	I needed this type of care but was not able to access it.	I did not need this type of care.
Routine medical care	☐	☐	☐
Dental (mouth) care	☐	☐	☐
Mental health care	☐	☐	☐
Reproductive health care	☐	☐	☐
Emergency care for a mental health crisis, including suicidal thoughts	☐	☐	☐
Treatment for a substance use disorder	☐	☐	☐
Vision care	☐	☐	☐
Medication for a chronic illness	☐	☐	☐

12. For any types of care that you needed <u>but were not able to access</u>, select the reason(s) why you were unable to access care.

	Concern about COVID exposure	Unable to afford the costs	Unable to get transportation	Hours did not fit my schedule	Fear or distrust of health care system	No providers speak my language	Another reason not listed
Routine medical care	☐	☐	☐	☐	☐	☐	☐
Dental care	☐	☐	☐	☐	☐	☐	☐
Mental health care	☐	☐	☐	☐	☐	☐	☐
Reproductive health care	☐	☐	☐	☐	☐	☐	☐
Emergency care for a mental health crisis, including suicidal thoughts	☐	☐	☐	☐	☐	☐	☐
Treatment for a substance use disorder	☐	☐	☐	☐	☐	☐	☐
Vision care	☐	☐	☐	☐	☐	☐	☐
Medication for a chronic illness	☐	☐	☐	☐	☐	☐	☐

If you selected "Another reason not listed" in the table above, please explain why you were unable to get the care you needed:

_____

13. How much do you agree with the following statements?

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
Healthcare in my community is impacted by systemic racism. This is the kind of racism that happens when big institutions—like government, health care, housing, etc.—work in ways that provide resources and power to people who are white, and fewer or none to people of color. This kind of racism is aimed at whole groups of people instead of at individuals and is not always done on purpose.	☐	☐	☐	☐	☐
Healthcare in my community is impacted by individual racism. This is the racism that happens when one person (or group of people) has negative attitudes towards another person (or group of people)—because of the color of their skin, physical features, culture and/or language—and treats the other person/group badly/unfairly.	☐	☐	☐	☐	☐

Experiences with Discrimination

14. It has been shown that experiencing discrimination negatively impacts the health and well-being of individuals and communities. In order to better understand these impacts, BILH would like to hear about your lived experience regarding discrimination. In the following questions, we are interested in the ways you are treated. To the extent that you are comfortable, can you tell us if any of the following happens to you, and if so, how often?

	Never	Less than once a year	A few times a year	A few times a month	At least once a week	Almost every day
You are not hired for jobs for unfair reasons, are unfairly fired, or are denied a raise.	☐	☐	☐	☐	☐	☐
You are unfairly stopped, searched, questioned, threatened, or abused by the police.	☐	☐	☐	☐	☐	☐
You receive worse service than other people at stores, restaurants, or service providers.	☐	☐	☐	☐	☐	☐
Landlords or realtors refused to rent or sell you an apartment or house.	☐	☐	☐	☐	☐	☐
Healthcare providers treat you with less respect or provide worse services to you compared to other people.	☐	☐	☐	☐	☐	☐

15. If you answered a few times a year or more, what do you think is the main reason for these experiences? You may select more than one.

- ☐ Ableism (discrimination on the basis of disability)
- ☐ Ageism (discrimination on the basis of age)
- ☐ Discrimination based on income or education level
- ☐ Discrimination based on the basis of religion
- ☐ Discrimination based on the basis of weight or body size
- ☐ Homophobia (discrimination against gay, lesbian, bisexual, or queer people)
- ☐ Racism (discrimination on the basis of racial or ethnic group identity)
- ☐ Sexism (discrimination on the basis of sex)
- ☐ Transphobia (discrimination against transgender or gender non-binary people)
- ☐ Xenophobia (discrimination against people born in another country)
- ☐ Don't know
- ☐ Prefer not to answer

16. Is there anything else you would like to share about the community you selected in the first question? If not, leave blank.

_____

_____

_____

About You

The following questions help us to better understand how people of diverse identities and life experiences may have similar or different experiences of the community. You may skip any question you prefer not to answer.

17. What is your age?

- ☐ Under 18
- ☐ 18-24
- ☐ 25-44
- ☐ 45-64
- ☐ 65-74
- ☐ 75-84
- ☐ 85 and over
- ☐ Prefer not to answer

18. What is your current gender identity?

- ☐ Genderqueer or gender non-conforming
- ☐ Man
- ☐ Transgender
- ☐ Woman
- ☐ Prefer to self-describe: _____

19. What is your sexual orientation?

- ❑ Bisexual
- ❑ Gay or lesbian
- ❑ Straight/heterosexual
- ❑ Prefer to self-describe: _____
- ❑ Prefer not to answer

20. Which of these groups best represents your race? You will have space to enter ethnicity in the next question. (Please check all that apply.)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic/Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Not listed above/Other: _____
- ☐ Prefer not to answer

21. What is your ethnicity? (You can specify one or more)

- ☐ African (specify_____)
- ☐ African American
- ☐ American
- ☐ Brazilian
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Caribbean Islander (specify_____)
- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ European (specify_____)
- ☐ Filipino
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Indian
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican, Mexican-American, Chicano
- ☐ Middle Eastern (specify_____)
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ Vietnamese
- ☐ Other (specify_____)
- ☐ Unknown/not specified

22. What is the primary language(s) spoken in your home? (Please check all that apply.)

- ☐ Armenian
- ☐ Cape Verdean Creole
- ☐ Chinese (including Mandarin and Cantonese)
- ☐ English
- ☐ Haitian Creole
- ☐ Hindi
- ☐ Khmer
- ☐ Portuguese
- ☐ Russian
- ☐ Spanish
- ☐ Vietnamese
- ☐ Other: _____
- ☐ Prefer not to answer

23. What is the highest grade or level of school that you have completed?
- ☐ Never attended school
- ☐ Grades 1 through 8
- ☐ Grades 9 through 11/ Some high school
- ☐ Grade 12/Completed high school or GED
- ☐ Some college, Associates Degree, or Technical Degree
- ☐ Bachelor's Degree
- ☐ Any post graduate studies
- ☐ Prefer not to answer

24. Are you currently:
- ☐ Employed full-time (40 hours or more per week)
- ☐ Employed part-time (Less than 40 hours per week)
- ☐ Self-employed (Full- or part-time)
- ☐ A stay at home parent
- ☐ A student (Full- or part-time)
- ☐ Unemployed
- ☐ Unable to work for health reasons
- ☐ Retired
- ☐ Other (specify_____)
- ☐ Prefer not to answer

25. How long have you lived in the United States?
- ☐ Less than one year
- ☐ 1 to 3 years
- ☐ 4 to 6 years
- ☐ More than 6 years, but not my whole life
- ☐ I have always lived in the United States
- ☐ Prefer not to answer

26. Have you served on active duty in the U.S. Armed Forces, Reserves, or National Guard?
- ☐ Never served in the military
- ☐ On active duty now (in any branch)
- ☐ On active duty in the past, but not now (includes retirement from any branch)
- ☐ Prefer not to answer

27. Do you identify as a person with a disability?
- ☐ Yes
- ☐ No
- ☐ Prefer not to answer

28. How would you describe your current housing situation?
- ☐ I rent my home
- ☐ I own my home
- ☐ I am staying with another household
- ☐ I am experiencing homelessness or staying in a shelter
- ☐ Other (specify_____)
- ☐ Prefer not to answer

29. Are you the parent or caregiver of a child under the age of 18?
- ☐ Yes (Please answer question 30)
- ☐ No
- ☐ Prefer not to answer

30. If you are the parent or caregiver for a child under 18, please indicate the age(s) of the child(ren) you care for. (Please check all that apply.)
- ☐ 0-3 years
- ☐ 4-5 years
- ☐ 6-10 years
- ☐ 11-14 years
- ☐ 15-17 years

31. Many people feel a sense of belonging to communities other than the city or town where they spend the most time. Which of the following communities do you feel you belong to? (Select all that apply)
- ☐ My neighborhood or building
- ☐ Faith community (*such as a church, mosque, temple, or faith-based organization)*
- ☐ School community *(such as a college or education program that you attend, or a school that you child attends)*
- ☐ Work community *(such as your place of employment, or a professional association)*
- ☐ A shared identity or experience *(such as a group of people who share an immigration experience, a racial or ethnic identity, a cultural heritage, or a gender identity)*
- ☐ A shared interest group *(such as a club, sports team, political group, or advocacy group)*
- ☐ Another city or town where I do not live
- ☐ Other (Feel free to share: _____)

If you would like to be entered into the drawing to win a $100 gift card, please enter your name and the best way to contact you in the box (phone number or email). This information will not be used to identify your answers to the survey in any way. Please detach this sheet, and return the survey and this sheet to the place you picked it up.

First Name and Email or Phone:

If you would like to be added to an email list to hear about future Beth Israel Lahey Health hospital meetings or activities, please enter your email address below. This information will not be used to identify your answers to the survey in any way. Please detach this sheet, and return the survey and this sheet to the place you picked it up.

Email:

Thank you so much for your help in improving your community!

Next
Back
Done

Beth Israel Lahey Health

Survey Distribution Channels: Global View Communications

Engaging with Diverse Communities

Survey Campaign Dates: November 1, 2021 – November 15, 2021.

Connecting with our diverse communities to understand and address the most pressing health-related concerns for residents is priority for BILH. GVC have deployed a marketing campaign to reach our target populations through a three-phase approach. First is an online survey which is followed by a listening session and then an annual meeting.

Our Approach

Research was conducted to determine the diverse target audiences based on zip codes surrounding our 10 hospitals and then cross-referenced with the top 2-to-3 diverse populations and languages based on the largest cohorts. That research indicated the following audiences: Hispanic, Black/African American, Chinese, Haitian, Indian, and Cape Verdean.

Winchester Hospital	Beverly/Addison Gilbert Hospital	Lahey Hospital and Medical Center	Anna Jaques Hospital	Beth Israel Deaconess Medical Center
01801 01806 01807 01808 01813 01815 01864 01867 01876 01880 01887 01888 01889 01890 02155 02156 02180 02153	01901 01902 01903 01904 01905 01910 01915 01923 01929 01930 01931 01937 01938 01944 01965 01966 01949	02420 02421 02474 02475 02476 01850 01851 01852 01853 01854 01960 01961 01730 01731 01803 01805 01821 01822 01862 01865 01940	01830 01831 01832 01833 01834 01835 01860 01913 01950 01951 01952 01985 01969	02445 02446 02447 02173 02492 02467
Mt. Auburn Hospital	**New England Baptist**	**BID – Milton Hospital**	**BID - Needham Hospital**	**BID – Plymouth Hospital**
02138 02139 02140 02141 02142 02143 02144 02145 02238 02239 02451 02452 02453 02454 02455 02474 02472 02474 02475 02476 02477 02478 02479	02445 02446 02447 02467 02026 02027	02169 02170 02171 02186 02187 02269 02368	02492 02494 02026 02027 02030 02090	02330 02331 02332 02345 02355 02360 02361 02362 02364 02366 02381

Channels

GVC utilized three types of marketing channels to expand our reach. Diverse print publications, precision audio, and digital advertising.

1. Print

The following print publications were selected based on reach or hyper targeted audiences. Translation was used if the publication publishes in languages other than English.

A. El Mundo – Spanish Translation

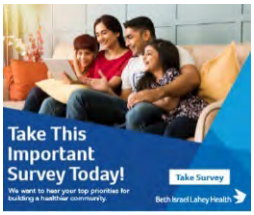
B. Sampan – Chinese Translation

C. Thang Long – Vietnamese Translation

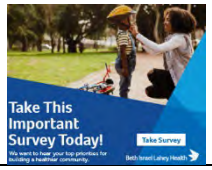
D. Bay State Banner – Black/African American, Cape Verdean/English

E. Chelsea Record – Hispanic/English

F. Indian New England – English (online only)



G. Haitian Reporter – English (online only)



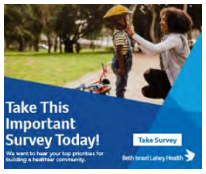
For the printed newspapers the publish dates are as follows:

Bay State	4-Nov
El Mundo	4-Nov
Sampan	5-Nov
Haitian Report (digital only)	2 weeks
Thang Long	2-Nov
India New England (digital only)	2 weeks
Chelsea	4-Nov

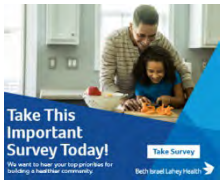
2. Digital Advertising

Digital ads will be served across various websites. GVC utilized a people-based marketing approach. The digital ads will be served up based on the zip codes provided and will include both English and translations based on user preferences. For social media and audio these ads run for a full 2 weeks from Nov 1 through Nov 15.

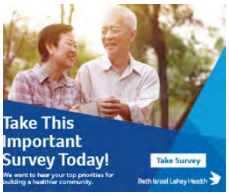
A. African American/Black, Haitian, Cape Verdean



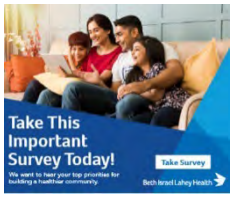
B. Hispanic



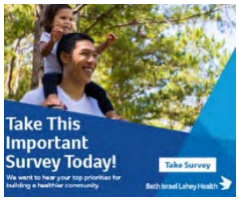
C. Chinese



D. Indian



E. Vietnamese



C. Precision Audio

GVC streamed :30 audio spots across multiple platforms (iHeart, NPF, PODcasts, Pandora, Spotify, etc.). GVC served up audio commercial voiceover for each hospital using zip codes. For social media and audio these ads run for a full 2 weeks from Nov 1 through Nov 15.

Sample audio script. Note: Script was customized for each of the 10 hospitals.

Beth Israel Deaconess Medical Center wants to hear what you think the most important health-related priorities are in our community. Please take an online survey at bilh.org/chna. Your responses will help to inform innovative solutions to improve the health of our community. Simply go to bilh.org/chna and fill out the survey. That's b-i-l-h.org/c-h-n-a.

Note: For social media and precision audio, this campaign is people based, so GVC is following each audience member and serving ad messaging where ever and whenever they are consuming online content (within the set frequency for the campaign).

For example, one person could be more active online early mornings – reading articles when he/she/they wake up; listening to streamed music while he/she/they commute – so GVC would then be sure to serve Mike his daily ad frequency during the times he is more active online, increasing the likelihood for click conversion with display ads – or in the case of audio, listening to the ad through to 100% completion. So basically going off of the targets media consumption.

Boston CHNA-CHIP Collaborative Community Health Needs Assessment Report

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EXECUTIVE SUMMARY

BACKGROUND

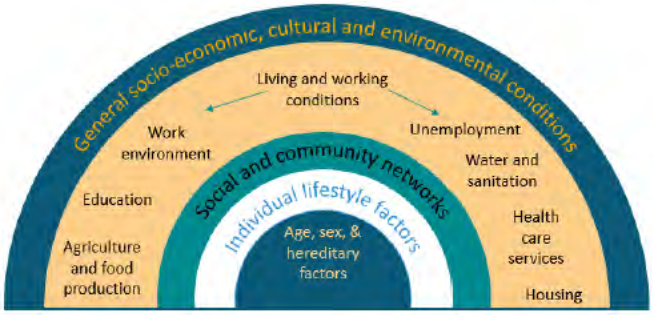
The Boston CHNA-CHIP Collaborative (the Collaborative) is a group of Boston health centers, community-based organizations, community residents, hospitals, and the Boston Public Health Commission. The Collaborative aims to achieve sustainable positive change in the health of the city by partnering with communities, sharing knowledge, aligning resources, and addressing root causes of health inequities. In 2019, the Collaborative conducted the first large-scale joint citywide community health needs assessment (CHNA) which then guided the city's community health improvement plan (CHIP), a blueprint describing how the Collaborative would focus on collectively addressing the key priorities.

In 2021-2022, the Collaborative worked together to develop the 2022 Boston CHNA. The 2022 Boston CHNA builds on the 2019 CHNA and takes a deep dive into the key priority areas identified in the 2020 community health improvement plan: housing, financial stability and mobility, behavioral health, and accessing services. The 2022 CHNA was conducted during an unprecedented time, including the COVID-19 pandemic and a reckoning with systemic racism.

METHODS

This CHNA focuses on the social determinants of health and is guided by a health equity lens. In the U.S., social, economic, and political processes work together to assign social status based on race and ethnicity, which may affect access to opportunities, such as educational and occupational mobility and housing options, each of which are intimately linked with health. Historical oppression, institutional racism, discriminatory policies, and economic inequality are several root factors that shape health inequities across the U.S.

Social Determinants of Health Framework



Source: World Health Organization, Commission on the Social Determinants of Health, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, 2005.

Existing secondary data were reviewed from national, state, and city sources, including datasets such as the American Community Survey, Boston Behavioral Risk Factor Surveillance System (BBRFSS), BBRFSS COVID-19 Health Equity Survey, and vital records, among other sources. For new data collection, key informant interviews were conducted with 62 leaders across sectors and 29 focus groups were facilitated with 309 residents who have been particularly burdened by social, economic, language, and health challenges. We use the term "residents" throughout the report to refer to participants in focus groups, interviews, and community listening sessions.

COMMUNITY ASSETS AND STRENGTHS

- Residents described their communities as deeply connected, resilient, committed to solving problems, and comprised of several supportive community-based organizations.
- Key informants and focus group participants talked about their communities as being vibrant, full of rich cultural traditions, having a strong history of activism and art, intelligent, innovative, and committed to solving problems.

> *"The community has come together for food distributions, to work together as a community to support the community with food access. There is always more to do, but this is a way that we have improved and supported each other."*
> - Focus group participant

OVERALL HEALTH AND MORTALITY

- Community Health Perceptions: Top of mind health concerns for focus group and interview participants were mental health, substance use, heart disease, diabetes, asthma, and obesity, all of which they perceived as being harder to tackle during the pandemic.
- Leading Causes of Death: COVID-19 was the leading cause of death for Black, Latino, and Asian residents in Boston in 2020. Additional leading causes of death were chronic diseases and accidents.

Leading Causes of Mortality, by Boston and Race/Ethnicity, Age-Adjusted Rate per 100,000 Residents, 2020

	Boston	Asian	Black	Latino	White
1	**COVID-19** 138.4	**COVID-19** 95.1	**COVID-19** 238.1	**COVID-19** 143.5	**Cancer** 117.6
2	**Cancer** 117.4	**Cancer** 92.8	**Heart Disease** 183.6	**Heart Disease** 86.1	**Heart Disease** 113.1
3	**Heart Disease** 114.9	**Heart Disease** 55.4	**Cancer** 166.7	**Cancer** 78.8	**COVID-19** 103.5
4	**Accidents** 53.7	**Cerebrovascular Diseases** 22.2 †	**Accidents** 82.7	**Accidents** 59.5	**Accidents** 53.2
5	**Cerebrovascular Diseases** 27.4	**Accidents** 17.1 †	**Cerebrovascular Diseases** 52.8	**Diabetes** 27.4	**Chronic Lower Respiratory Diseases** 24.7

DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Deaths, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office

FINANCIAL STABILITY AND MOBILITY: Jobs, Employment, Income, Education, and Workforce Training

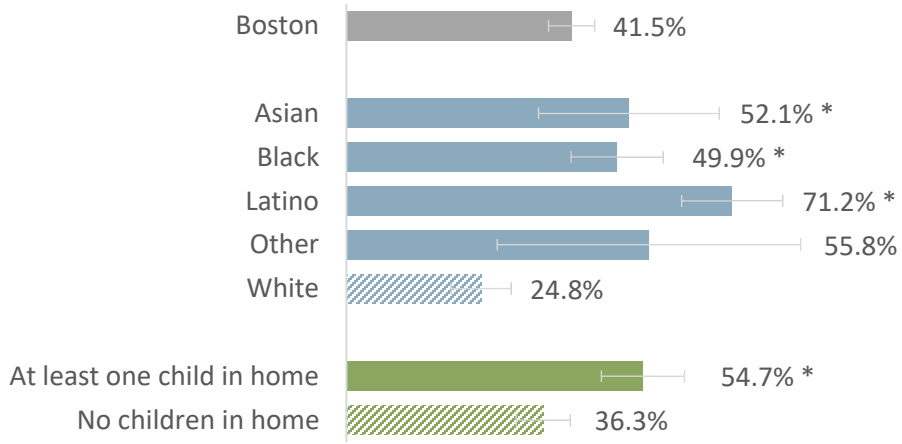
- Income and Poverty: Community leaders and residents described financial stability as critical for health and shared that low-wage work and minimum wage is insufficient for many families to survive in Boston. Residents noted that the pandemic has worsened poverty for low-income residents across Boston. Based on the COVID-19 Health Equity Survey, income loss during the pandemic has disproportionately affected residents of color and low-income residents.

- Food Insecurity: Barriers to accessing healthy, affordable food emerged as a priority issue, which worsened during the pandemic and by the rising cost of food. According to the COVID-19 Health Equity Survey, food insecurity is greatest among residents of color and adults with children at home.
- Employment: Interview and focus group participants described significant job loss linked with the pandemic and noted that finding and securing stable jobs is more difficult for residents of color, immigrants, people with disabilities, and residents with a criminal record. They also shared that low-wage workers, especially immigrants, worked in high-risk job settings during the pandemic.
- Education: Focus group and interview participants described remote learning and the pandemic as particularly hard for youth who already face disproportionate challenges in school. According to the COVID-19 Health Equity Survey, 14.5% of Boston adults with children reported unmet educational needs for children or teens during the pandemic.

HOUSING: Affordability, Quality, Homelessness, Homeownership, Gentrification, and Displacement

- Housing Affordability: Interview and focus group participants cited housing affordability as a dominant concern that has been exacerbated by the pandemic due to high housing costs and employment fluctuations. In the COVID-19 Health Equity Survey, 41.5% of adults reported having trouble paying their rent or mortgage during the pandemic, with highest proportions reported among residents of color and adults with children at home.
- Housing Instability and Transiency: Community leaders and residents described housing assistance as insufficient to meet the needs of low-income residents and expressed concern about ending rental assistance programs instituted during the pandemic. Residents underscored how the lack of affordable housing contributes to homelessness and housing instability, overcrowded housing, and housing displacement – which adversely affect mental health.
- Housing Conditions, Overcrowding, and COVID-19: Residents noted that COVID-19 cases often affected several household members, which they linked to dense living conditions that make it difficult to isolate or quarantine and people working multiple jobs outside of the home.

Percent Adults Reporting Having Trouble Paying Their Rent or Mortgage During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Questionnaire, December 2020 - January 2021

BEHAVIORAL HEALTH: Mental Health and Substance Use

- Trauma, Discrimination, and Racism: Residents discussed that some groups are disproportionately affected by trauma, discrimination, and racism, including: residents of color, lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual (LGBTQIA+) communities, veterans, people with disabilities, people who have experienced violence, low-income residents, and those who lost loved ones during the pandemic. In the 2015-2019 BBRFSS, reports of being threatened at least a few times a month due to discrimination were highest among Black and Latino residents.

> *"The trauma also perpetuates these issues, and the environment also perpetuates these issues and systemically the services that we don't get perpetuates these issues. So that is why racism is a public health crisis."*- Key informant interview

- Community Violence and Interactions with Police: Some residents discussed community violence and safety concerns as well as increased neighborhood conversations about community and police relations. In 2015-2019, the most recent years for which data are available, BBRFSS respondents' reports of feeling like they were stopped by police due to their race or ethnicity were highest among residents of color.
- Mental Health, Depression, and Suicide: Mental health was a key issue pre-pandemic and the impact of the pandemic only heightened that concern, particularly for children, youth, and caregivers. According to the COVID-19 Health Equity Survey, during the pandemic 16.8% of Boston adults reported experiencing persistent sadness and 21.9% reported persistent anxiety during the pandemic for more than half of the days in the past 2 weeks. Notably, 29.2% of LGBTQIA+ Youth Risk Behavior Survey (YRBS) student respondents reported having had suicidal thoughts in 2015-2019.
- Behavioral and Mental Health Care Access and Barriers to Care: Residents discussed several barriers to accessing mental health care, including a limited number of mental health providers, financial barriers, a lack of culturally appropriate and linguistically congruent care, and stigma surrounding mental health care. Based on the COVID-19 Health Equity Survey, 9.9% of Boston adults reported delaying mental health care due to the pandemic and 7.1% reported delaying mental health care because of cost.
- Substance Use: Substance use concerns that emerged include misuse of drugs, overusing prescriptions and over-the-counter medicines, and smoking nicotine and marijuana, particularly among LGBTQIA+ residents and youth. According to COVID-19 Health Equity Survey, 27.8% of Boston adults reported increased drinking habits during the pandemic.

ACCESSING SERVICES: Childcare, Social Services, and Health Care

- Accessing Childcare Services: In focus groups and interviews, childcare emerged as a growing need due to the pandemic. According to the COVID-19 Health Equity Survey, 14.3% of Boston adults reported that children in their households experienced unmet childcare needs during the pandemic.
- Accessing Social and Other Services: Residents and community leaders discussed rising and acute social and economic needs among a growing segment of low-income residents and significant barriers to accessing services, such as: transportation, difficulty navigating application processes, limited Internet, and lack of eligibility due to immigration status. Several participants also discussed systemic racism, racial injustice, and discrimination. In 2015-2019 BBRFSS data, 28.4% of Boston residents reported receiving poor service at restaurants or stores in day-to-day life due to their race or ethnicity, with a higher proportion of respondents of color indicating having this experience.

- Accessing Health Care Services: Residents identified barriers to accessing health care, including: income, health insurance, distrust towards providers, difficulty navigating the health care system, transportation, difficulty securing a medical appointment, language barriers, and limited culturally relevant care. Residents described how racial and ethnic inequities in health care access and social factors – such as transportation and Internet access – have been magnified by the COVID-19 pandemic.

> *"Due to my language barriers, I was not able to express my health concerns and had a hard time to communicate with doctors to get right treatment."*- Focus group participant

COMMUNITY'S VISION AND COMMUNITY SUGGESTIONS FOR THE FUTURE

Interview and focus group participants were asked for their suggestions for addressing identified needs and their vision for the future. Suggestions included the following:

- Deepen Partnerships with Local Communities and Collaborate to Promote Health Equity
- Focus on Dismantling Systemic Racism
- Create Opportunities that Foster Economic Stability and Mobility
- Improve Housing Affordability
- Improve Access to and Quality of Behavioral Health Care
- Strengthen Health Care Policies and Improve Health Care Access and Quality
- Promote Child and Youth Development
- Create a Healthier Built and Physical Environment

PRIORITIES FOR COLLABORATIVE ACTION

For the past two years, the Boston CHNA-CHIP Collaborative has been implementing the 70 strategies outlined in the 2020 community health improvement plan. Great progress has been made on many of these strategies, while other strategies have not been implemented as extensively given constrained capacity and the current context of the COVID-19 pandemic.

Given this backdrop, the 2022 prioritization process focused on:

1) reaffirming the previous priorities and identifying any new issues that have emerged; and
2) prioritizing specific strategies within these major areas that should be lifted up for future action.

In May-June 2022, 62 participants were engaged in four community listening sessions to discuss the CHNA findings, provide feedback on the data and key priority areas, and systematically vote on the 2020 CHIP strategies for more focused implementation. The results reaffirmed the CHIP's priorities of:

- **Housing** (including affordability, quality, homelessness, ownership, gentrification, and displacement)
- **Financial Security and Mobility** (including jobs, employment, income, education, and workforce training which comprised this priority in the past CHIP, and including food security which emerged as a salient issue in the 2022 CHNA)
- **Behavioral Health** (including mental health and substance use)
- **Accessing Services** (including health care, childcare and social services)

Boston CHNA-CHIP Collaborative
2022 Community Health Needs Assessment

BACKGROUND

This report is the 2022 community health needs assessment for the Boston CHNA-CHIP Collaborative. A community health needs assessment, or CHNA, gathers community input and data to gain a greater understanding of the strengths of the community, the issues that residents face, how those issues are currently being addressed, and where there are gaps and opportunities to address these issues in the future. CHNAs provide a data-informed foundation for planning and the development of initiatives.

The Boston CHNA-CHIP Collaborative (the Collaborative) is a group of Boston community residents, community-based organizations, community development corporations, health centers, the hospitals, and the Boston Public Health Commission. This group has come together to achieve sustainable positive change in the health of the city by collaborating with communities, sharing knowledge, aligning resources, and addressing root causes of health inequities. One of the fundamental approaches for this work is to conduct a community health needs assessment so efforts are informed by data and community members themselves. While community health assessment and planning have been long-standing endeavors among organizations across the city, the Collaborative aims to leverage, align, and coordinate efforts and resources across multi-sector stakeholders in Boston. More details about the Collaborative's structure and engagement can be found in the Methods section of this report, Appendices A-C, and at http://www.bostonchna.org/.

Purpose and Context of the 2022 Community Health Needs Assessment

In 2019, the Collaborative conducted the first large-scale joint citywide CHNA which then guided the city's community health improvement plan (CHIP), a blueprint describing how the Collaborative would focus on collectively addressing the key priorities. The 2022 Boston CHNA builds on those efforts by taking a deep dive into the key priority areas identified in the previous CHIP: housing, financial stability and mobility, behavioral health, and accessing services.

This 2022 CHNA was conducted during an unprecedented time, including the COVID-19 pandemic, which exacerbated many social and economic inequalities that have been present for generations. The pandemic contributed to a staggering number of COVID-19 cases, deaths, and ongoing health challenges which disproportionately affected marginalized populations. During this same period, there has been a growing national movement calling for racial equity to address racial injustices in the U.S. The growth of this movement has been sparked by the killings of several Black Americans including George Floyd and Ahmaud Arbery. In 2020, the City of Boston declared racism as a public health crisis, underscoring the City's commitment to dismantle structural racism and recognize historical injustice.

This context shaped the assessment approach and content, in that the 2022 Boston CHNA also explores how the pandemic and racial injustices have affected priorities that emerged from the previous CHIP.

These processes have been guided by the Collaborative's shared values of:

- **Equity**: Focus on inequities that affect health with an emphasis on race and ethnicity;
- **Inclusion**: Engage diverse communities and respect diverse viewpoints;
- **Data driven**: Be systematic in our process and employ evidence-informed strategies to maximize impact;
- **Innovative**: Implement approaches that embrace continuous improvement, creativity, and change;
- **Integrity**: Carry out our work with transparency, responsibility, and accountability;
- **Partnership**: Build trusting and collaborative relationships between communities and organizations to foster sustainable, community-centered change.

Definition of Community Served

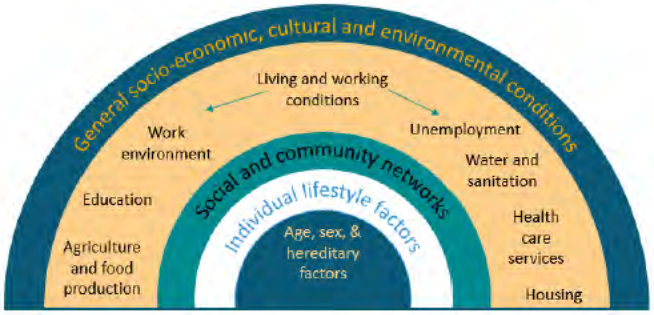
The 2022 Boston CHNA focused on the geographic area of the City of Boston. When available and appropriate, the data are presented for Boston overall and by different sub-populations. This includes by race/ethnicity, neighborhood, and other defining characteristics.

METHODS

Social Determinants of Health Framework

This CHNA focuses on the social determinants of health and is guided by a health equity lens (Figure 1). The contexts in which population groups live, learn, work, and play have a profound impact on health. There is often a deep connection between how race, ethnicity, income, geography, and other factors shape health patterns. In the U.S., social, economic, and political processes work together to assign social status based on race and ethnicity, which may affect access to opportunities, such as educational and occupational mobility and housing options, each of which are intimately linked with health. Historical oppression, institutional racism, discriminatory policies, and economic inequality are several of the root factors that shape persistent and emerging health inequities across the U.S.

Figure 1. Social Determinants of Health Framework



Source: World Health Organization, Commission on the Social Determinants of Health, Towards a Conceptual Framework for Analysis and Action on the Social Determinants of Health, 2005.

Review of Secondary Data

The 2022 Boston CHNA data gathering effort included a review of existing secondary data on social, economic, and health indicators. These indicators provide insights into patterns across Boston, by Boston neighborhood, and by population groups within Boston. Secondary data sources included U.S. Census/American Community Survey, vital statistics (birth/death records), hospital case mix data,

Boston Behavioral Risk Factor Surveillance Survey (BBRFSS), BBRFSS COVID-19 Health Equity Survey, Youth Risk Behavior Survey (YRBS), and the Massachusetts Department of Public Health Bureau of Substance Addiction Services treatment data.

The Secondary Data Work Group of the Collaborative included 16 members representing a range of organizations, including hospitals, health centers, and local public health. The Secondary Data Work Group's charge was to provide guidance on secondary data approach and indicators and foster connections with key networks and groups to provide relevant data (See Appendix B for list of members).

To identify the list of social, economic, and health indicators, Secondary Data Work Group members reviewed the indicator list from the 2019 Boston CHNA and prioritized which indicators should be revisited for the 2022 report. The secondary data work group engaged in multiple discussions and prioritized the secondary data that aligned with the 2019 priority areas; that COVID-19 had a disproportionate impact on, and/or where there were the greatest inequities by race/ethnicity, neighborhood, or other characteristics.

Secondary data in the 2022 CHNA represent the most recent data available, and in several cases overlap with data included in the 2019 CHNA due to the need to combine data across years to look at patterns by neighborhood and social and demographic factors. Qualitative discussions (described in the section that follows) build upon the secondary data by shedding light on residents' recent experiences with and perspectives on many factors, including the social determinants of health and how these issues have been affected by the COVID-19 pandemic. Additional detail on the secondary data approach can be found in Appendix D, while Appendix F presents numerous additional data tables and graphs beyond what is covered in the body of this report.

Qualitative Discussions and Community Engagement

The Community Engagement Work Group includes 24 members representing a range of organizations, including health centers, local public health, community development, community-based organizations, and hospitals. The Work Group's charge is to provide guidance on the approach to community engagement, input on primary data collections methods, and support with logistics for primary data collection (See Appendix B for list of members). The Collaborative's Community Engagement Work Group led efforts to gain insight into community needs and strengths as well as priorities from community leaders and residents, especially among those where there has been a gap in representation in previous processes. Altogether, they facilitated 29 virtual and in-person focus group discussions with a total of 309 residents who have been disproportionately burdened by social, economic, and health challenges including: youth and adolescents, older adults, persons with disabilities, low-resourced individuals and families, LGBTQIA+ populations, racially/ethnically diverse populations (e.g., African American, Latino, Haitian, Cape Verdean, Vietnamese, Chinese), limited-English speakers, immigrant and asylee communities, families affected by incarceration and/or violence, and veterans. Some focus groups were conducted in languages other than English, including Spanish, Chinese, and Vietnamese. Please see Appendix D for more details on the community engagement process and qualitative data approach.

Collaborative members conducted key informant interviews with 62 individuals. These represented a cross-section of sectors to identify areas of action and perspectives on the community. These interviewees included leaders and staff from public health, health care, behavioral health, the faith community, immigrant services, housing organizations, economic development, community

development, racial justice organizations, social service organizations, education, community coalitions, the business community, childcare centers, elected government offices, and others. Please see Appendix E for a list of key informant interviewee organizations.

Additionally, Collaborative members conducted four 90-minute virtual Community Listening Sessions in January 2022. A total of 122 community members participated in these four sessions. These sessions occurred mid-way into the CHNA process and provided an opportunity to gather feedback and insights on preliminary data findings and potential priorities at this point in time. During these sessions, Collaborative members shared preliminary themes from focus groups, interviews, and the review of secondary data. The participants discussed their reactions and feedback to these preliminary findings in small groups and identified areas that were their highest priority for action.

To deepen understanding of issues that were salient to respondents, interview, focus group, and community listening session discussion guides used open-ended questions and did not ask about specific topics. Community engagement work group members and their partners conducted the focus groups and interviews, and then summarized the key themes from the discussions they facilitated. These summaries were then analyzed to identify common themes and sub-themes across population groups as well as unique challenges and perspectives identified by populations and sectors, with an emphasis on diving deep into the root causes of inequities. Frequency and intensity of discussions on a specific topic were key indicators used for extracting main themes. Additional information on the qualitative data collection and analysis process can be found in Appendix D. We use the term "residents" throughout the report to refer to participants in focus groups, interviews, and community listening sessions.

Limitations

While the data sources used in this CHNA are highly credible, there are some important limitations and considerations that are important to keep in mind. Qualitative discussions use small sample sizes and non-random sampling methods, the latter of which is an important approach to incorporating the perspectives of communities who were underrepresented in previous processes. Moreover, due to the ongoing COVID-19 pandemic, Collaborative members conducted the majority of interviews and focus group discussions remotely, which may have affected participation – both in terms of who is able to participate remotely and the information elicited in remote discussions.

Secondary data may have a time lag and apply different ways of measuring variable such as neighborhoods. Additionally, BBRFSS data from 2015-2019 are the most recent data available regarding the experiences, health behaviors, and self-reported health and health care patterns among Boston residents. Given the need to aggregate data across years to look at patterns across neighborhoods and population groups, data from the 2015-2019 period overlap with data reported in the 2019 community health needs assessment. Finally, COVID-19 data provide a snapshot in one moment in time in the ongoing pandemic and are not representative of the entire pandemic.

2022 CHNA: A Snapshot in Time during the COVID-19 Pandemic

The COVID-19 pandemic has been an important and evolving backdrop to the 2022 Boston CHNA, and thus shapes how the COVID-19 pandemic has affected priority areas identified in the 2019 CHNA. Despite access to vaccinations beginning in late 2020 and early 2021, there have been multiple increases in case rates linked with the onset of the Delta and Omicron variants. The COVID-19 pandemic is marked by significant changes and inequities in health, the economy, and the workforce. Given the unprecedented nature of the COVID-19 pandemic, it is critical now, more than ever, to understand community needs, experiences, and opportunities for the future.

We also recognize how the pandemic has shaped this process. As part of the BBRFSS, a separate COVID-19 Health Equity Survey was conducted by the Boston Public Health Commission to better understand experiences among residents who have been most impacted by the pandemic. This survey of a random sample of over 1,650 residents in multiple languages was conducted in December 2020/January 2021 and examined issues related to job loss, food insecurity, access to services, mental health, as well as COVID-19 risk perceptions, vaccination, and information sources.

Additionally, the COVID-19 pandemic affected the data collection methods as most of the focus groups and interviews occurred by telephone or video conference. Not surprisingly, the COVID-19 pandemic came up quite a bit during the discussions – but less about the disease itself, and more about how the pandemic has highlighted long-standing and existing inequities that have been pervasive in Boston and the U.S. For these reasons, findings should be understood as capturing a snapshot in an unprecedented moment in time.

BOSTON POPULATION – RACE, ETHNICITY, AND LANGUAGE

Boston's population is incredibly diverse in terms of race and ethnicity, country of birth, and language use. While the racial and ethnic distribution across Boston has remained similar since the 2019 CHNA, the racial and ethnic composition is changing across neighborhoods.

Race and Ethnic Diversity

Historic disinvestment in communities of color are the root causes of racial inequities in the social determinants of health.[1] Racial and ethnic health and health care inequities are persistent and are among the leading public health challenges of our time. For example, people of color experienced a disproportionate burden of COVID-19-related income loss, cases, and deaths, whereas White residents appeared to weather the COVID-19 pandemic with fewer social, economic, and health costs.[2,3] Understanding the racial, ethnic, and language profiles of Boston residents provides context to data about health status and the structural, discriminatory, and social factors that contribute to health inequities.

Focus group participants and key informants discussed the racial diversity of residents across Boston as a unique strength, highlighting Black/African American, African, Latino, Cape Verdean, Haitian, Asian, and other Caribbean communities in the Boston area. According to Census estimates (

Table 1), approximately 3 in 5 (60.0%) Boston residents identify as people of color. Mattapan, Hyde Park, Dorchester, and Roxbury are home to the largest proportion of Boston residents who identify as Black. East Boston, Roxbury, Hyde Park, and Dorchester's 02121 and 02125 zip codes have the largest percent of residents who identify as Latino, while Fenway and Allston/Brighton are home to the largest proportion of Asian residents.

Table 1. Racial and Ethnic Distribution, by Boston and Neighborhood, 2020

	Asian	Black	Latino	White	Two or More Races
Boston	9.7%	25.2%	19.8%	44.5%	5.3%
Allston/Brighton	19.3%	4.9%	11.1%	59.0%	4.2%
Back Bay	12.7%	3.5%	7.4%	71.9%	3.7%
Charlestown	8.6%	5.2%	10.9%	71.3%	3.5%
Dorchester (02121, 02125)	11.4%	33.5%	23.7%	17.7%	9.5%
Dorchester (02122, 02124)	8.6%	39.5%	15.5%	29.1%	5.3%
East Boston	4.5%	3.3%	50.4%	36.6%	3.6%
Fenway	24.1%	6.6%	9.0%	55.0%	3.6%
Hyde Park	2.2%	45.7%	24.7%	21.9%	4.2%
Jamaica Plain	7.6%	10.0%	20.3%	56.2%	5.0%
Mattapan	1.0%	68.3%	21.0%	2.5%	5.6%
Roslindale	3.7%	15.4%	20.4%	55.3%	4.2%
Roxbury	11.0%	35.7%	27.3%	19.4%	5.0%
South Boston	5.1%	4.2%	10.4%	76.6%	2.9%
South End	15.6%	12.6%	14.7%	52.4%	3.9%
West Roxbury	7.4%	13.3%	13.0%	62.2%	3.3%

DATA SOURCE: U.S. Census, Decennial Census of Population and Housing, 2020
NOTE: Neighborhoods as defined by Boston Public Health Commission; Back Bay includes Back Bay, Beacon Hill, Downtown, North End, and West End; South End includes South End and Chinatown; Latino includes residents who identify as Latino regardless of race and race categories may include residents who identify as Latino; therefore, the percentages may not add up to 100%

Language and Immigrant Communities

A theme across several interviews and focus groups was that immigrant communities in the Boston area are hardworking, family- and community-oriented, willing to help others, eager to contribute socially and economically, and passionate about local issues and issues in their home countries. Several key informants and focus group participants observed that undocumented immigrants experienced additional barriers to housing, health insurance, and accessing resources and assistance programs, which they perceived were based on legal status and fear of deportation.

> *"I think [specific neighborhoods] are great for new immigrants. When you first come to the United States, you need help from others."*
> - Focus group participant

Key informants and focus group participants noted many languages spoken among residents, including Cantonese, Mandarin, Russian, Spanish, Haitian Creole, Cape Verdean Creole, and indigenous languages. Some residents described free English classes as an important resource for residents for whom English is not their first language. However, language barriers still emerged as an important issue affecting immigrant communities.

COMMUNITY ASSETS AND STRENGTHS

Residents described their communities as deeply connected, resilient, committed to solving problems, and comprised of several supportive community-based organizations.

Understanding the strengths of community members and community resources and services helps to identify the assets that can be drawn upon to promote community health and address any existing gaps. When asked about community strengths, residents discussed a strong sense of community among residents, especially those who have lived in neighborhoods for years. They described their neighbors as supporting each other even when they themselves have limited resources. Focus group participants described their neighbors as *"resilient"* and *"resourceful"* even under difficult circumstances. Key informants and focus group participants talked about their communities as being vibrant, full of rich cultural traditions, having a strong history of activism and art, intelligent, innovative, and committed to solving problems.

Focus group participants and key informants discussed the breadth of community-based institutions and services that they knew of, especially those focused on early childhood, youth, young men of color, food security, housing, mental health, health care, caregiver support, workforce development, and the LGBTQIA+ population. Resource sharing and collaboration among a network of community-based organizations was also discussed as a strength. Residents described other community strengths, including engaged elected officials, educational opportunities and the school system, green space (e.g., parks), accessible libraries, and easy access to the transportation system.

> *"The community has come together for food distributions, to work together as a community to support the community with food access. There is always more to do, but this is a way that we have improved and supported each other."*
> - Focus group participant

OVERALL HEALTH AND MORTALITY

Top of mind health concerns for focus group and interview participants were mental health, substance use, heart disease, diabetes, asthma, and obesity, all of which they perceived as being harder to tackle during the pandemic. Meanwhile, COVID-19 was the leading cause of death for Black, Latino, and Asian residents in Boston in 2020.

Community Perceptions of Health

Mental health, substance use, heart disease, diabetes, asthma, and obesity were most frequently brought up as health concerns during interviews and focus group discussions. Key informants and focus

group participants also described a high case rate of COVID-19 for immigrants and communities of color (e.g., Haitian, Cape Verdean, Latino) and for residents of color and low-wage workers who were not able to work from home.

Other health concerns discussed by community leaders and residents included cancer, dementia, Alzheimer's, osteoporosis, oral health, Black women's maternal health, and chronic obstructive pulmonary disease (COPD). Some key informants and focus group participants underscored how pre-existing conditions have worsened during the COVID-19 pandemic, including chronic conditions that are difficult to manage, conditions that have remained undiagnosed, and chronic conditions linked with trauma. Youth and LGBTQIA+ focus group participants described sleep as critical to promoting health and identified stress and anxiety as barriers to living a healthy lifestyle and getting adequate sleep. Several focus group participants, particularly youth and residents in Chinatown, cited environmental quality as being linked with health, including air pollution, poor ventilation, smoke from tobacco and marijuana use, and lack of cleanliness in the neighborhood.

Several focus group participants described physical activity, including going for a walk, playing sports, and working out, as important for feeling good, relieving stress, and overall health. Focus group participants explained that during the COVID-19 pandemic they have not been able to do as much physical activity and have been quite sedentary. As one participant mentioned, *"People have not been active through COVID – kids and adults have put on so much weight – some have become obese. I am worried about the kids – they don't get enough activity."* Focus group participants cited the importance of and need for green space (e.g., parks, access to walking paths) to enable residents to spend time outside safely and to be physically active in an affordable way. Several focus group participants noted the importance of clean neighborhoods, including air quality and trash. LGBTQIA+ focus group participants also described a need for gyms that are more welcoming to LGBTQIA+ residents.

> *"It seems like almost every family has high blood pressure, high cholesterol, or diabetes."*
> -Focus group participant

Additional data on health issues such as asthma, birth outcomes, and physical activity can be found in Appendix F.

Overall Mortality

In 2020, COVID-19 was the leading cause of death for Black, Latino, and Asian residents in Boston, whereas cancer was the leading cause of death for White residents (

Table 2). Additional leading causes of death were accidents and chronic diseases, such as cancer, heart disease, and cerebrovascular diseases. In the 2019 Boston CHNA, cancer was the leading cause of death across each of the largest racial and ethnic groups in Boston.

Table 2. Leading Causes of Mortality, by Boston and Race/Ethnicity, Age-Adjusted Rate per 100,000 Residents, 2020

	Boston	Asian	Black	Latino	White
1	**COVID-19** 138.4	**COVID-19** 95.1	**COVID-19** 238.1	**COVID-19** 143.5	**Cancer** 117.6
2	**Cancer** 117.4	**Cancer** 92.8	**Heart Disease** 183.6	**Heart Disease** 86.1	**Heart Disease** 113.1
3	**Heart Disease** 114.9	**Heart Disease** 55.4	**Cancer** 166.7	**Cancer** 78.8	**COVID-19** 103.5
4	**Accidents** 53.7	**Cerebrovascular Diseases** 22.2 †	**Accidents** 82.7	**Accidents** 59.5	**Accidents** 53.2
5	**Cerebrovascular Diseases** 27.4	**Accidents** 17.1 †	**Cerebrovascular Diseases** 52.8	**Diabetes** 27.4	**Chronic Lower Respiratory Diseases** 24.7

DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Deaths, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Massachusetts Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events; Dagger (†) denotes where rates are based on 20 or fewer deaths and may be unstable

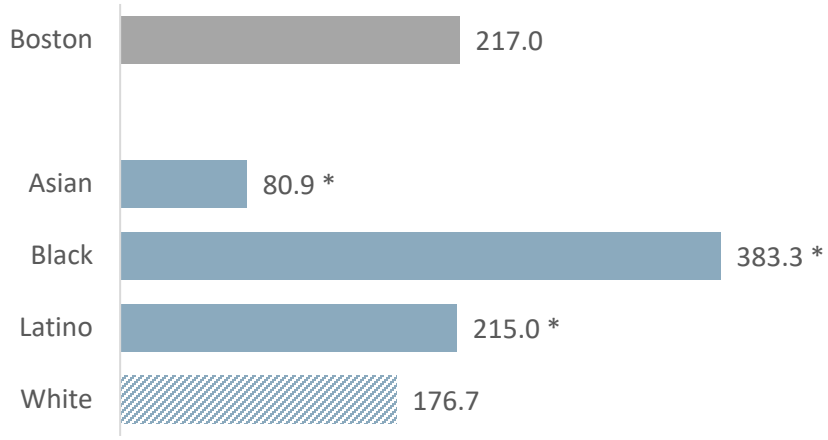
Of note, the cancer mortality rate for each of Boston's largest racial and ethnic groups in 2020 was lower than that reported in the 2019 community health needs assessment. During this same period, the heart disease mortality rate appeared to increase among Black residents, decrease for Asian and White residents, and remained relatively stable for Latino residents. Since the 2019 community health needs assessment, the accident-related mortality rate increased for Black and Latino residents, remained relatively stable for White residents, and emerged as a leading cause of death for Asian residents. The rate of mortality due to cerebrovascular disease increased for Black residents, remained stable for Asian residents, and did not emerge as the top five causes of mortality for Latino and White residents, likely due to COVID-19 becoming a leading cause of death in 2020. The diabetes-related mortality rate remained stable for Latino residents since the 2019 community health needs assessment. (It should be noted that changes in mortality rates over time were not tested for statistically significant differences.)

Premature mortality refers to deaths among persons under 65 years of age. The premature mortality rate in 2020-2021 was highest among Black and Latino residents (

Figure 2). Of note, the premature mortality rate for Black residents is more than double the premature mortality rate for White residents.

Accidents was the leading cause of premature mortality among all race/ethnicities in Boston except for Asian residents, who experienced cancer as the leading cause of premature death (Table 3). COVID-19 was the second leading cause of premature mortality among Latino residents, underscoring the impact of the pandemic among this community. Notably, homicide is the fifth leading cause of death in Black and Latino communities and the homicide mortality rate for Black residents exceeds the cancer mortality rate for White residents.

Figure 2. Premature Mortality Rate, by Boston and Race/Ethnicity, Age-Adjusted Rate per 100,000 Residents, 2020-2021 Combined



DATA SOURCE: Boston Public Health Commission, Boston resident deaths, 2020-2021 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Premature deaths are defined as deaths at an age under 65 years; Bars with pattern indicate reference group for its specific category; Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events.
Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05).

Table 3. Leading Causes of Premature Mortality, by Boston and Race/Ethnicity, Age-Adjusted Rate per 100,000 Residents, 2020

	Boston	Asian	Black	Latino	White
1	**Accidents** 48.0	**Cancer** 28.7 †	**Accidents** 77.0	**Accidents** 56.7	**Accidents** 46.5
2	**Cancer** 31.1	**Accidents** 12.9 †	**Heart Disease** 58.9	**COVID-19** 33.3	**Cancer** 25.7
3	**Heart Disease** 28.4	**Heart Disease** 11.9 †	**Cancer** 53.7	**Cancer** 23.2	**Heart Disease** 24.2
4	**COVID-19** 17.8	**Suicide** 6.1 †	**COVID-19** 34.1	**Heart Disease** 20.9	**COVID-19** 8.9
5	**Homicide** 7.5		**Homicide** 30.6	**Homicide** 8.8 †	**Chronic Liver Disease & Cirrhosis** 8.6

DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Deaths, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Premature deaths are defined as deaths at an age under 65 years; Insufficient number of records for analysis for Asian residents; Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Massachusetts Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events;
Dagger (†) denotes where rates are based on 20 or fewer deaths and may be unstable

CHIP PRIORITY AREA - FINANCIAL STABILITY AND MOBILITY: JOBS, EMPLOYMENT, INCOME, EDUCATION, AND WORKFORCE TRAINING

Community leaders and residents discussed how the COVID-19 pandemic has worsened already existing income inequalities and the level and severity of poverty for low-income residents across Boston.

Financial stability and mobility - including income, jobs, employment, education, and workforce training - was a priority area in the 2019 Boston CHNA-CHIP. Income, work, and education are powerful social determinants of health. Jobs that pay a living wage enable workers to live in neighborhoods that promote health (e.g., built environments that promote physical activity and resident engagement, better access to affordable healthy foods), and provide income and benefits to access health care.[4] In contrast, unemployment, underemployment, and job instability make it difficult to afford housing, goods and services that are linked with health, and health care, and also contribute to stressful life circumstances that affect multiple aspects of health.[5]

Income and Poverty

In the 2019 Boston CHNA, poverty and economic instability emerged as key areas of concern among residents and there were substantial differences in income and financial security across Boston neighborhoods and by race and ethnicity.

> *"My husband has 2 jobs so we can pay the rent and food, clothing, everything. It is really difficult now, this situation that is happening."*- Focus group participant

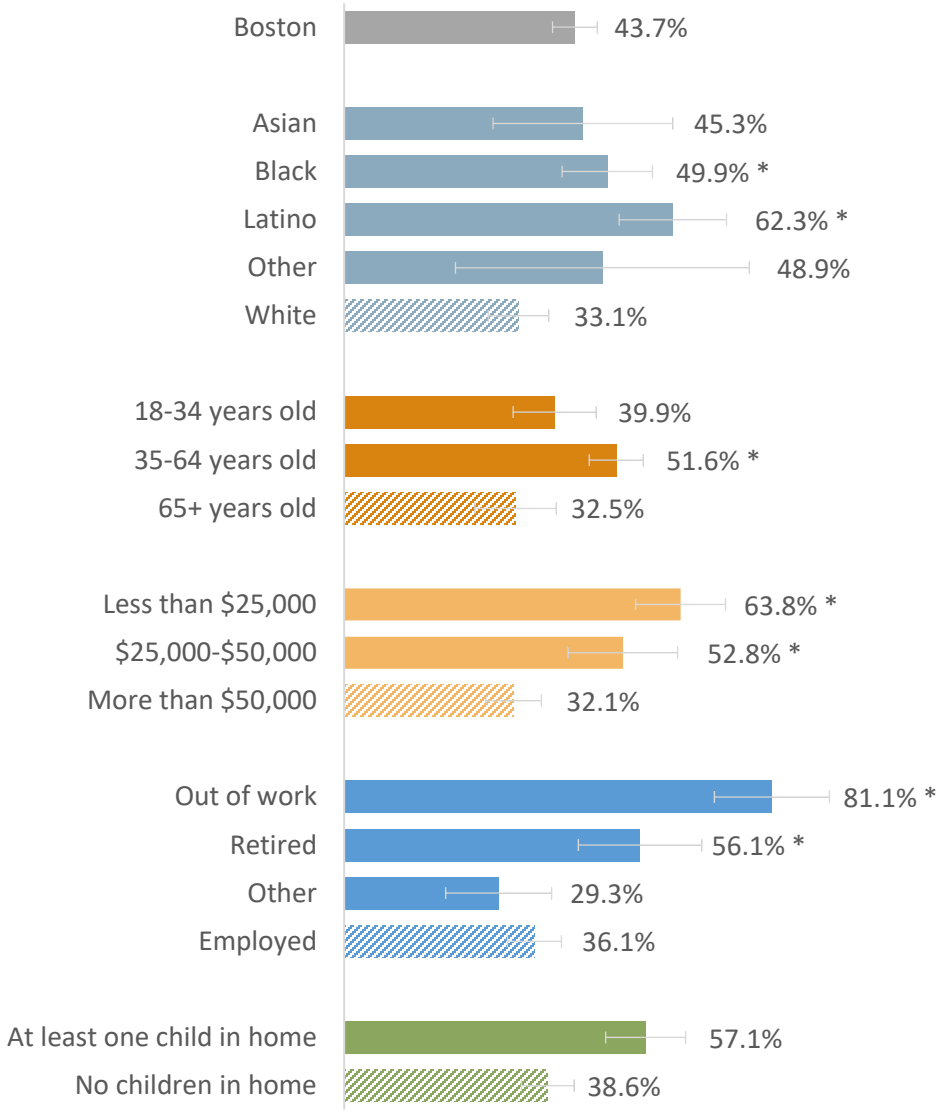
Similar to the past process, focus group participants and key informants engaged in the 2022 Boston CHNA described financial stability as critically important for health. Key informant interviewees and focus group participants shared that the COVID-19 pandemic has worsened income inequalities and the level and severity of poverty for low-income residents across Boston. According to the COVID-19 Health Equity Survey, income loss during the pandemic has disproportionately affected residents of color and low-income residents, described in more detail below. Key informants and focus group participants noted that low-income communities in Boston generally include residents of color, immigrants, people with disabilities, LGBTQIA+ residents, and older adults on fixed incomes.

Focus group participants and key informants noted that low-wage work and minimum wage is not enough for many families to survive in Boston, and that many residents are having to work multiple jobs to make ends meet. Several interviewees and focus group participants discussed that while income loss has affected many people, they were most concerned about those residents who were already struggling before the pandemic – this includes low-income communities, residents of color and in particular immigrants, people with disabilities, and residents with a criminal record. They described the cost of living as high and rising, including escalating housing and food costs while wages have not increased. As one participant noted, *"Food prices have gone up a lot while my wage has stayed the same."* From April 2021 to April 2022, food prices increased an estimated 9.4%.[6]

Some key informants noted that neighborhoods that have historically experienced disinvestment continue to experience greater challenges to growth and development, and small businesses in low-income communities have been hit hard by the COVID-19 pandemic. Some elected officials described insufficient access to capital and financial instability as barriers to community development. Some key informants perceived that limited funding – and competition for this limited funding – contributes to some organizations not collaborating to provide access to resources.

As shown in Figure 3, over 4 in 10 Boston adults (43.7%) reported that they had experienced a loss of income during the COVID-19 pandemic. Residents who identified as Black or Latino were most affected by income loss, with about 62.3% of Latino respondents indicating that they had income loss during the pandemic and nearly half of Black residents reporting income loss. More than half of adults 35-64 years of age, adults with lower incomes, and adults with at least one child in the home reported income loss during the pandemic. When looking at income loss by occupational status, a higher proportion of adults who were out of work or retired reported income loss during the pandemic, compared to employed adults.

Figure 3. Percent Adults Reporting Experiencing an Income Loss During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting their household had experienced a loss of employment income since COVID-19 occurred; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

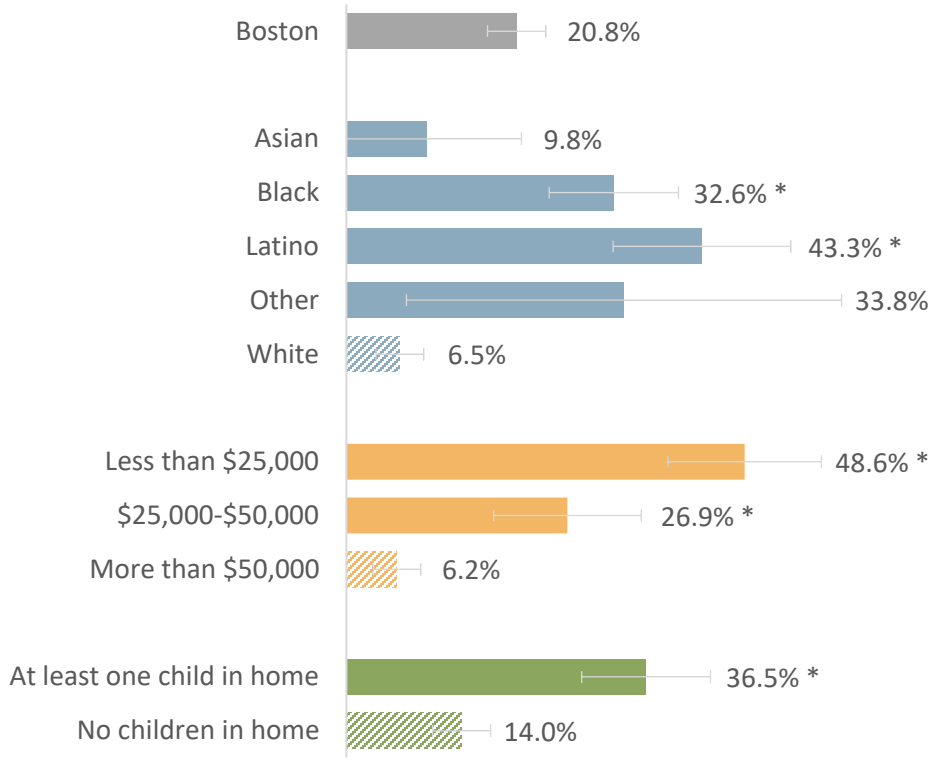
Food Insecurity

Struggling to make ends meet is directly linked with struggling to put food on the table. Food insecurity, namely barriers to accessing healthy, affordable food emerged as a key priority issue across many interviews and focus groups. Food insecurity patterns indicate that a greater proportion of residents report experiencing food insecurity since the COVID-19 pandemic.

> *"Folks are struggling with [food] affordability. Inflation on goods has been astronomical."* - Focus group participant

Pre-pandemic, 2015-2019 BBRFSS data show that about 17.8% of Boston residents were identified as food insecure – in that the food they purchased ran out before they had money to buy more (see Figure 42 in Appendix F). The burden of food insecurity was even greater in Mattapan, Dorchester, and East Boston compared to the rest of Boston (see Figure 43 in Appendix F). Many residents reported being food insecure during the pandemic. According to the COVID-19 Health Equity Survey, while 20.8% of Boston residents were considered food insecure during the pandemic, about 43.3% of Latino residents were food insecure, as well as 32.6% of Black residents (**Figure 4**). The prevalence of food insecurity was also higher among adults who had a child at home compared to adults without children.

Figure 4. Percent Adults Reporting Food Purchased Did Not Last and Did Not Have Money to Get More During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



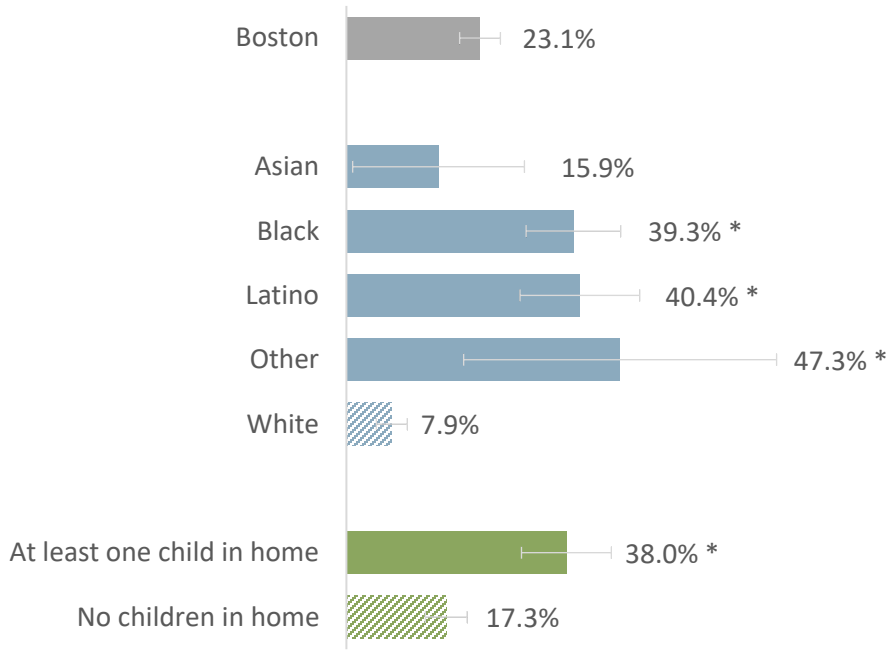
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Community leaders and residents discussed that healthy food is available, but not accessible to lower-income residents. As noted by a focus group participant, *"We live in a food desert. I have to travel out of town to find healthy food. The grocery store in [my neighborhood] doesn't carry the same healthy foods as towns that are more affluent. I feel badly for those who don't have a car and don't have access to healthier food*."

Participants also talked about how the cost of food is rising, contributing to growing levels of food insecurity as residents struggled to afford food, let alone healthy food. As one focus group participant mentioned, *"Access to healthy food is challenging because food costs are so high. When you have a big family, it gets very complicated. Healthy food is very connected to a healthy community."* Several residents underscored that many low-income residents have not been able to eat healthy foods during the COVID-19 pandemic due to financial constraints and some residents – such as older adults – face barriers to safely accessing food due to concern about virus transmission.

Many residents are accessing food assistance. According to the COVID-19 Health Equity Survey, about 23.1% of Boston adults reported using food assistance services during the COVID-19 pandemic (Figure 5), compared to 16.1% reported pre-pandemic. Approximately 40% of Latino (40.4%) and Black (39.3%) adults reported using food assistance services during the COVID-19 pandemic, compared to 7.9% of White adults. Additionally, 38.0% of adults with children in the home reported using food assistance during the COVID-19 pandemic, compared to 17.3% of adults who did not have children in the home.

Figure 5. Percent Adults Reporting Utilizing Food Assistance Services During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Food assistance services include food banks, food stamps, or other sources; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

Employment

Employment provides income, benefits, and economic stability, which is important for health.[7] While pre-pandemic Boston enjoyed a low unemployment rate, unemployment was highest during that time in Roxbury, Dorchester, Fenway, and Mattapan (see Figure 46 in Appendix F).

A key pattern that emerged from interviews and focus groups was significant job loss linked with the COVID-19 pandemic. Similar to the rest of the country, the greater Boston metropolitan area fluctuated dramatically in unemployment rate during the pandemic. According to the Bureau of Labor Statistics, the Boston metro area's unemployment rate was 16.0% during the early stages of the pandemic in April 2020 and has dropped to 3.7% nearly two years later in February 2022. Additionally, as of December 2021, an estimated 56,900 workers in Massachusetts have left the labor force; this pattern is not reflected in current unemployment rates.[8]

> *"I see that there is work and people apply […]. I've applied [to] a lot of places and am not given jobs. It says 'apply, help wanted,' but if you don't know anyone you won't be considered."* - Focus group participant

Employment Challenges

Even with more opportunities available, focus group and interview participants observed that some residents are still struggling to find jobs after losing work during the COVID-19 pandemic. Residents explained that it has been more difficult for residents of color, immigrants, people with disabilities, and residents with a criminal record to find and secure stable jobs. For example, interviewees discussed the barrier of being flagged for a criminal record: *"People can have a CORI for the silliest thing, and it follows [them] for the rest of [their] life and can prevent them from being hired."* Immigrant focus group participants discussed the challenges of being undocumented, as one resident mentioned, *"If you don't have a social [security number], you can't get a job. Even at McDonald's."* Others talked about the importance of needing to know someone at the place of employment to even be considered for a job.

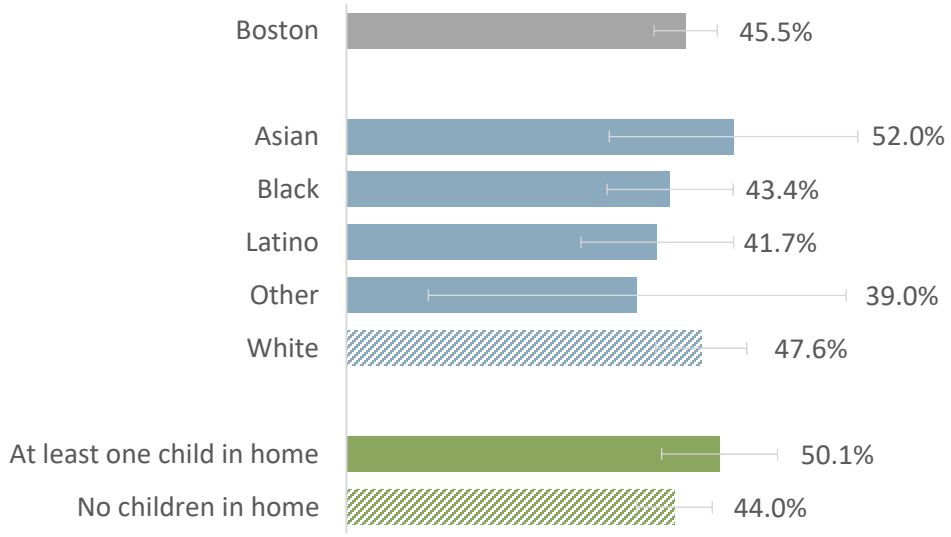
Elected officials and focus group participants cited lack of access to workforce development training as a concern. As one focus group participant commented, *"[I]f you don't have the training, you won't be considered. There need to be more options."* Some participants described experiencing discrimination in hiring, citing that Black men and those with disabilities seem to be the least likely to be hired for some positions. Some youth focus group participants observed that college is too expensive and expressed interest in more resources to pursue career options that do not require a college degree.

Employment and the COVID-19 Pandemic

Residents also discussed their employment challenges during the height of the pandemic. They recalled how unemployment applications were a major burden, and many working undocumented immigrants who are paid informally were not able to apply for or access payroll protection or COVID-19 relief funds. Focus group participants and key informants mentioned that low-wage workers, especially immigrants, worked in high-risk job settings with limited personal protective equipment (PPE). As shown in Figure 6, nearly half -- 45.5% -- of Boston residents indicated that they worked outside of their home during the COVID-19 pandemic.

On the positive side, some participants in focus groups and interviews mentioned a growth in the ability to work remotely, which they described as helpful for residents who experience transportation barriers and persons with complex health issues.

Figure 6. Percent Adults Reporting Working Outside of the Home During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting they worked at least part of the time at a workplace outside of home since the COVID-19 pandemic began; Percentage does not include adults who did not work for pay at all; Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Education

Education is an important issue to Boston residents and a critical factor affecting health. Community leaders and residents discussed how many children struggle in school, especially during the pandemic. Based on the COVID-19 Health Equity Survey, about 14.5% of Boston adults with children reported that they had unmet educational needs for children or teens during the COVID-19 pandemic (see Appendix F for data tables).

> *"If you have an asthmatic student and they are constantly out especially in the wintertime […] asthma doctors should educate parents and tell them about resources like getting a 504 plan […] so they won't get in trouble for truancy and ensure the child has support while there in school."*- Key informant interview

Focus group and interview participants discussed that remote learning and the COVID-19 pandemic was particularly hard for youth who already face disproportionate challenges in school. In the 2021-2022 school year, 30.1% of Boston Public School students were identified as Limited English Proficient (LEP) or English Language Learners (ELL) and nearly 68.9% of students were considered economically disadvantaged (participating in one or more state-administered programs of SNAP, TAFDC, DCF, or MassHealth). Interview and focus group participants discussed the need for greater investment to meet

the social, emotional, and academic needs of these children and youth. In particular, participants discussed their insufficient access to early childhood education, the need for more after school programs, support for enrolling children in school with proper educational plans in place, school dropout, health and economic barriers that affect school attendance, and the need for adult English classes for residents for whom English is not their primary language. From the 2020 to 2021 academic school year, PreK-12th grade Massachusetts student enrollment declined by 37,396 students.[9]

CHIP PRIORITY AREA - HOUSING: AFFORDABILITY, QUALITY, HOMELESSNESS, HOMEOWNERSHIP, GENTRIFICATION, AND DISPLACEMENT

As in previous assessments, housing affordability is a dominant concern among Boston residents and leaders and has only been exacerbated during the pandemic.

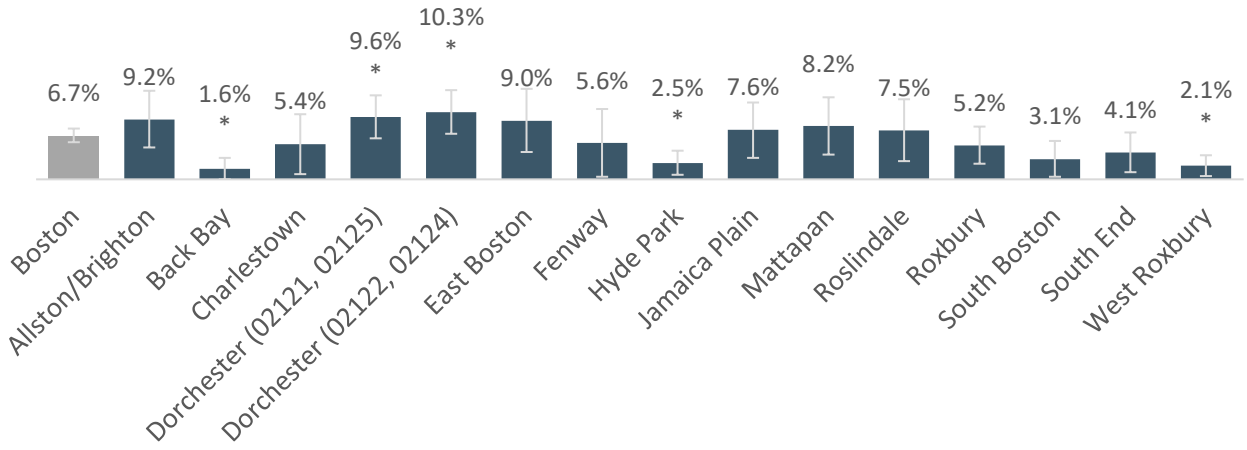
Housing - including housing affordability, quality, homelessness, homeownership, gentrification, and displacement - was a priority area identified in the 2019 community health needs assessment and community health improvement plan. Housing is typically the largest household expense, and, for homeowners, housing can be an important source of wealth.[10,11] For low-income residents, housing instability, the stress of unaffordable housing costs, and poor housing quality increase the risk of adverse health outcomes.[12] Housing concerns in the city have been pervasive for years. The sentiment has not changed, and many residents have been even more concerned about being able to afford where they live during the COVID-19 pandemic.

> *"Every year they raise the rent. They stopped during the pandemic, but I was told that they are going to raise it again. I can't imagine how much they are going to raise it. I can't move to other places because it's worse there."*
> -Focus group participant

Housing Affordability

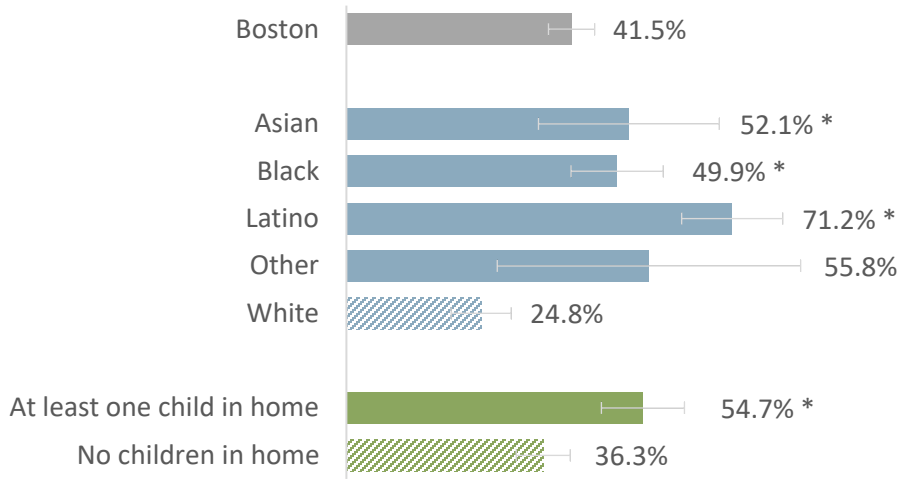
Pre-pandemic, an estimated 6.7% of Boston BBRFSS adult respondents in 2015-2019 reported moving in the past three years due to housing affordability. Reports of moving due to housing costs were highest for residents in Dorchester, Allston/Brighton, and Mattapan (Figure 7). In discussions, residents and leaders were even more concerned about high housing costs during the pandemic, especially given fluctuations in employment. In the COVID-19 Health Equity Survey, more than 4 in 10 respondents reported that they have had trouble paying their rent or mortgage during the COVID-19 pandemic, with highest proportions reported among Latino, Asian and Black adults, and adults with children in the home (Figure 8).

Figure 7. Percent Adults Reporting Moving in Past Three Years Because They Could No Longer Afford Their Home, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 8. Percent Adults Reporting Having Trouble Paying Their Rent or Mortgage During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting that it was somewhat or very difficult to pay the full amount of their rent or mortgage now; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

Key informants and focus group participants underscored that high housing costs affect low-income residents, residents of color, older adults, undocumented immigrants, immigrants more broadly, and people with disabilities. When discussing a lack of affordable housing, several residents in focus groups described a backdrop of gentrification and overdevelopment as a contributor to housing displacement for low-income residents. Some residents also discussed racism around unfair housing prices, language barriers to accessing housing, and discrimination in acceptance of housing vouchers by landlords and among those previously incarcerated. Focus group participants discussed high and rising rent, rising costs of housing and property taxes, and prioritizing paying rent over other health-promoting factors such as food and physical activity.

Housing Instability and Transiency

Participants discussed how the intersection between housing assistance and housing instability was a tenuous one. Some focus group participants noted that many landlords do not participate in rental assistance programs offered by the government, and that they are concerned that rental assistance programs instituted during the COVID-19 pandemic are coming to an end.

However, some residents also discussed the paradox of qualifying for low-income housing assistance, observing that the income threshold for affordable housing means that if residents earn higher wages, they stand to lose their housing voucher, yet they cannot afford housing at the market rate. Additionally, some key informants observed that while there were several policies enacted during the pandemic that aimed to help tenants stay in their homes (e.g., rent control, eviction moratorium), the increases in housing costs and limited availability of affordable housing were still major challenges.

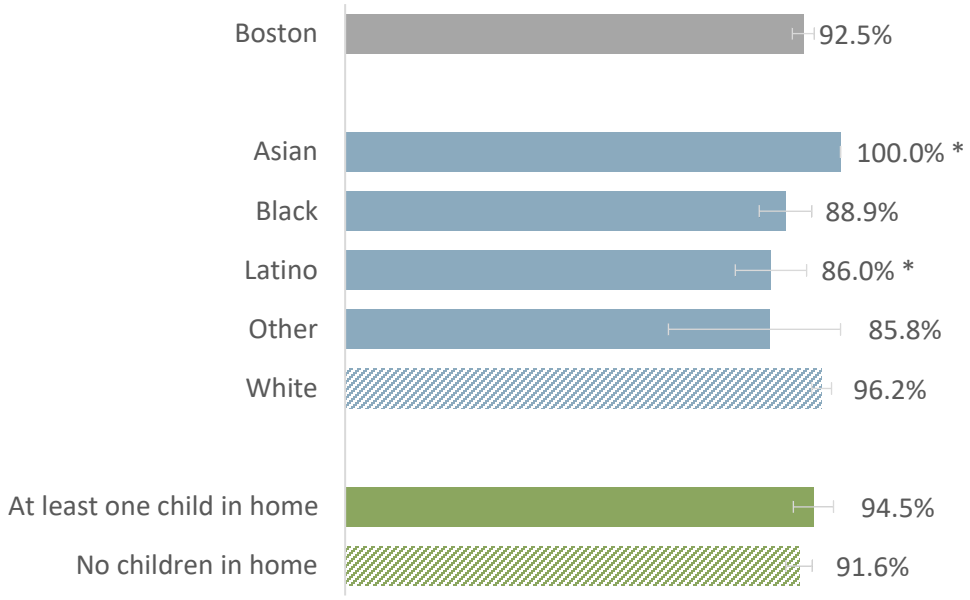
Residents shared that lack of affordable housing contributes to experiences of homelessness and housing instability, overcrowded housing, and housing displacement, each of which are linked with poor mental health outcomes.[13] Some interview and focus group participants noted that people experiencing homelessness include families and residents who were evicted from their homes and observed that people experiencing homelessness are often criminalized.

Housing Conditions, Overcrowding, and COVID-19

Focus group and interview participants discussed how the COVID-19 pandemic affected housing instability, homelessness, and increasingly residents moving in with others due to income loss, which contributes to overcrowded housing. Residents noted that COVID-19 cases often affect several household members, which they linked to multiple generations living in household and people working multiple jobs outside of the home. They noted that it is difficult to isolate or quarantine from family members due to dense living conditions. Participants discussed that these conditions, especially during COVID lockdown, also contribute to worsening mental health. As one focus group participant commented, "*When folks lost their jobs 2 years ago, they were suddenly crammed in houses, which affected physical health and mental well-being."*

Another critical aspect to housing infrastructure, especially during the pandemic is access to Internet. As discussed in the Access to Services section, Internet access became a critical household resource during the COVID-19 pandemic given the dependence on remote work, education, and health care for many populations. While about 9 in 10 Boston adults reported having Internet access at home during the COVID-19 pandemic, it is notable that a smaller percent of Latino adults reported Internet access at home compared to White adults (86.0% and 96.2%, respectively) (Figure 9).

Figure 9. Percent Adults Reporting Having Internet Access at Home During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

CHIP PRIORITY AREA - BEHAVIORAL HEALTH: MENTAL HEALTH AND SUBSTANCE USE

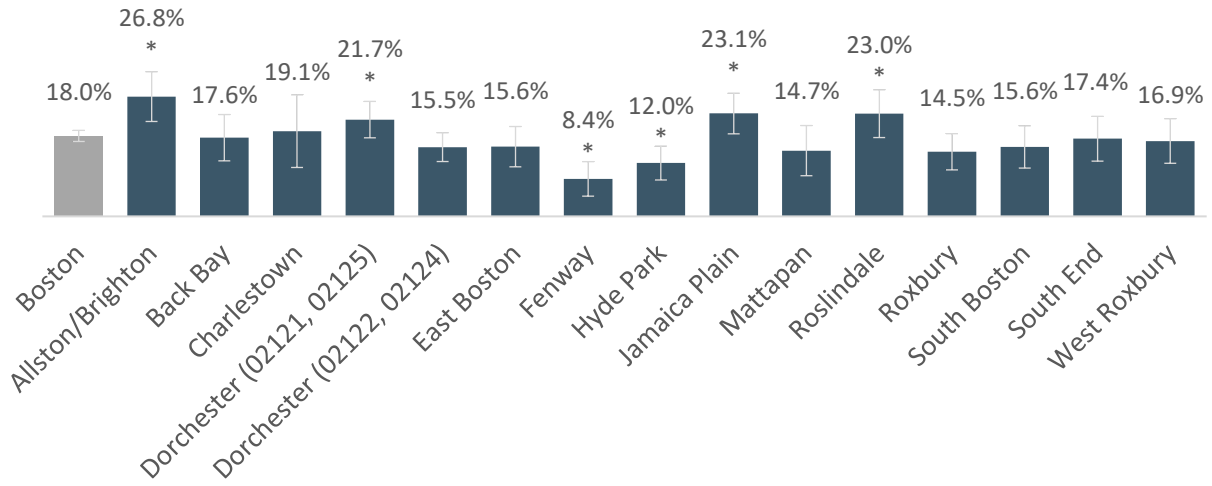
Community leaders and residents described trauma, stress, depression, and anxiety as top-of-mind concerns among all populations, but some groups were cited as being disproportionately impacted – such as youth, low-income households, caregivers, elders, and people of color.

Behavioral health, including mental health and substance use, was another priority area identified in the 2019 Boston community health needs assessment and improvement plan. Behavioral health is an overarching term for the connection between behaviors and people's mental and physical health.

Trauma, Racism, and Discrimination
Trauma and related issues were discussed among a number of residents and leaders in assessment conversations. Several participants discussed the characteristics of childhood trauma – such as racism, violence, poverty, home environments, housing conditions, addiction, neglect, and the loss of loved ones – and how they have affected all aspects of a person's life, including their health and their economic opportunity.

The mental health of caregivers is one of many potential sources of childhood trauma. About 18.0% of Boston residents reported having lived with a caregiver with mental illness as a child (Figure 10). About 1 in 4 adults in Allston/Brighton reported having lived with a caregiver with a mental illness when they were young, followed by about one in five adults in Jamaica Plain, Roslindale, and Dorchester (02121, 02125).

Figure 10. Percent Adults Reporting Having Lived with a Caregiver with Mental Illness as a Child (ACE), by Boston and Neighborhood, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting that they have ever lived with a parent or caregiver who was depressed, mentally ill, or suicidal; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

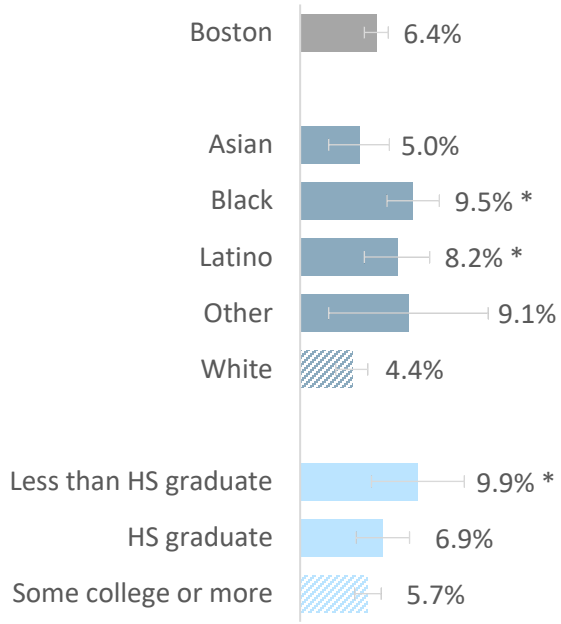
Veterans in focus groups discussed post-traumatic stress disorder as an issue pervasive in their community, while people with disabilities in focus groups noted how they experience mental health issues and trauma linked with their disability, such as bullying. Interview and focus group participants noted that these concerns have all increased during the pandemic. Additional traumatic stressors identified by key informants and focus group participants include community violence, domestic violence (especially during the pandemic and the challenges of staying home when in an abusive relationship), grief from loss of loved ones during the COVID-19 pandemic, and poverty.

Several participants described how racism and discrimination affects the mental well-being of residents of color, citing the role of intergenerational trauma, such as the history of slavery; stereotypes that devalue people of color; and "white-washing" critical histories and cultural practices of people of color. Several participants mentioned systemic racism and white supremacy as affecting multiple opportunities and facets of life, including jobs, housing, safety, and educational opportunities.

> *"The trauma also perpetuates these issues, and the environment also perpetuates these issues and systemically the services that we don't get perpetuates these issues. So that is why racism is a public health crisis."*- Key informant interview

As shown in Figure 11, 6.4% of BBRFSS respondents in 2015-2019 indicated that they have been threatened at least a few times a month due to discrimination. This is significantly greater among Black and Latino residents (9.5% and 8.2%, respectively). These numbers increase dramatically for residents who indicated they have been threatened at least once *a year* because of discrimination, with 17.3% of all Boston residents reporting this (see Appendix F for data tables).

Figure 11. Percent Adults Reporting Being Threatened At Least a Few Times a Month Due to Discrimination, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting being threatened or harassed due to discrimination a few times a month, at least once a week, or almost every day; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

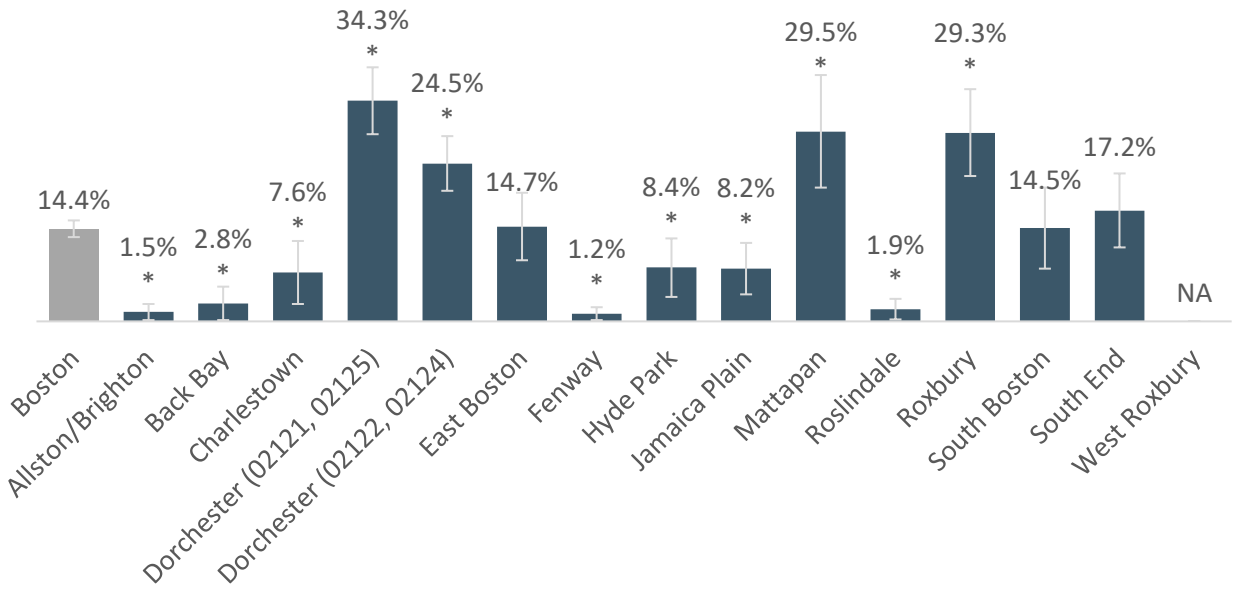
Focus group and interview participants also discussed discrimination specifically against LGBTQIA+ communities, particularly transphobia, as an important driver of mental health issues affecting

LGBTQIA+ communities. Participants also noted that LGBTQIA+ residents of color experience stress related to discriminatory experiences that target multiple aspects of their identities.

Community Violence and Interactions with the Police

Community violence and interactions with the police are public health issues that contribute to trauma and affect physical and mental health. Neighborhood safety concerns were a discussion topic among focus group and interview participants. According to 2015-2019 BBRFSS data, 14.4% of Boston residents perceived their neighborhoods as unsafe, with the highest percentage of residents from Dorchester (all zip codes), Mattapan, and Roxbury indicating concerns about neighborhood safety (Figure 12). Many focus group and interview participants reiterated these sentiments and also discussed that they were concerned about a decrease in neighborhood safety, particularly around gang-affiliated violence, during the pandemic.

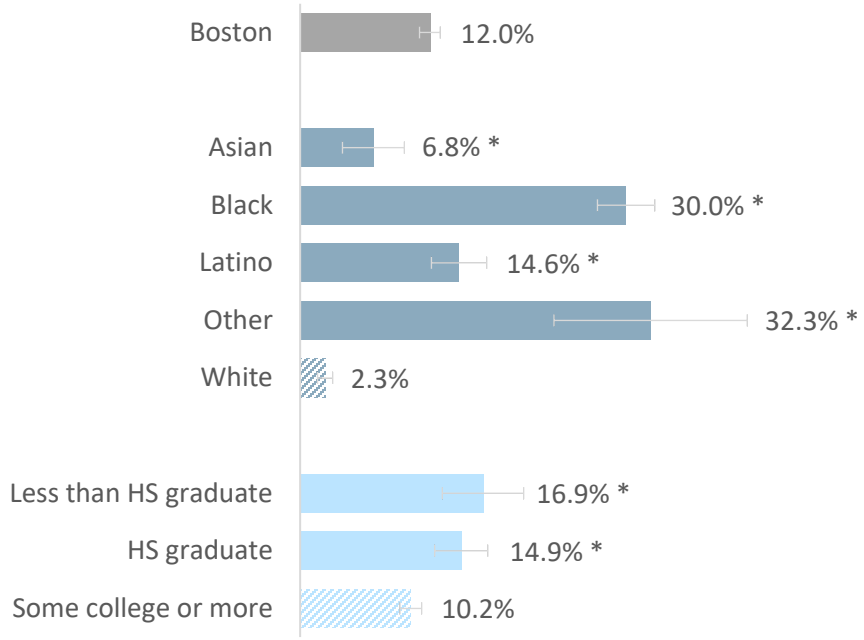
Figure 12. Percent Adults Reporting Their Neighborhood Unsafe, by Boston and Neighborhood, 2017 and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting considering their neighborhood to be unsafe from crime; NA denotes where data are not presented due to insufficient sample size; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Some focus group and interview participants also discussed the increased neighborhood conversations about the relationship between the community and police. While they saw an increase in greater dialogue around police violence towards communities of color, community leaders and residents noted that greater strides still needed to be made. According to 2015-2019 BBRFSS data, about 30.0% of Black adults in Boston and 14.6% of Latino adults reported ever feeling like they were stopped by police due to their race or ethnicity, compared to just 2.3% of White adults (Figure 13).

Figure 13. Percent Adults Reporting Ever Feeling They Were Stopped by Police Due to Race or Ethnic Background, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting ever feeling they were stopped by the police just because of their race or ethnic background; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

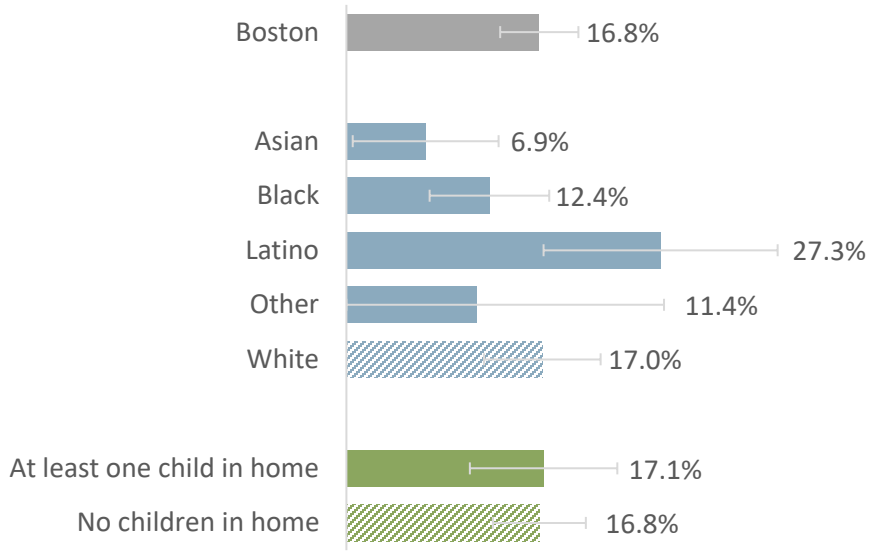
Mental Health, Depression, and Suicide

Mental health overall was a key issue pre-pandemic, and not surprisingly, the impact of the pandemic only heightened that concern. According to the COVID-19 Health Equity Survey, during the COVID-19 pandemic 16.8% of Boston adults reported experiencing persistent sadness – defined as feeling down, depressed, or hopeless more than half of the days in the previous 2 weeks (Figure 14). Overall, 21.9% of Boston adults reported feeling persistent anxiety during the pandemic – having felt nervous, anxious, or on edge for more than half of the days in the past 2 weeks (Figure 15).

Several focus group and interview participants discussed how the COVID-19 pandemic worsened mental health issues, including: social isolation, fear about contracting the virus, feeling overwhelmed by constant and changing information about the pandemic, and uncertainty about what the pandemic holds. In several discussions, participants also attributed the COVID-19 pandemic to worsening the high levels of stress that many low-income families already experience. They also noted that the resources that facilitate community connections, such as in-person meeting spaces and community centers, have been closed at times due to COVID-19 safety measures, and these closures hamper community building efforts. Some also noted that the COVID-19 pandemic contributes to trauma for older adults, who have lost many friends and family during the pandemic.

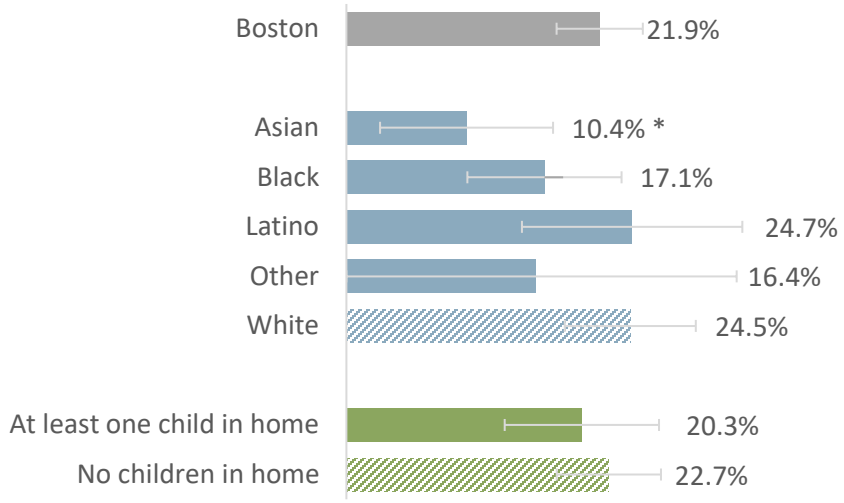
> *"Everything is so interwoven. [There are] a lot of young people with significant depression and anxiety, but [we're] also talking about a lot of PTSD, implications related to trauma, poverty, and neglect."*
> - Key informant interview

Figure 14. Percent Adults Reporting Persistent Sadness During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Persistent sadness is defined as feeling down, depressed or hopeless for more than half of the days within the past 2 weeks; Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Figure 15. Percent Adults Reporting Persistent Anxiety During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



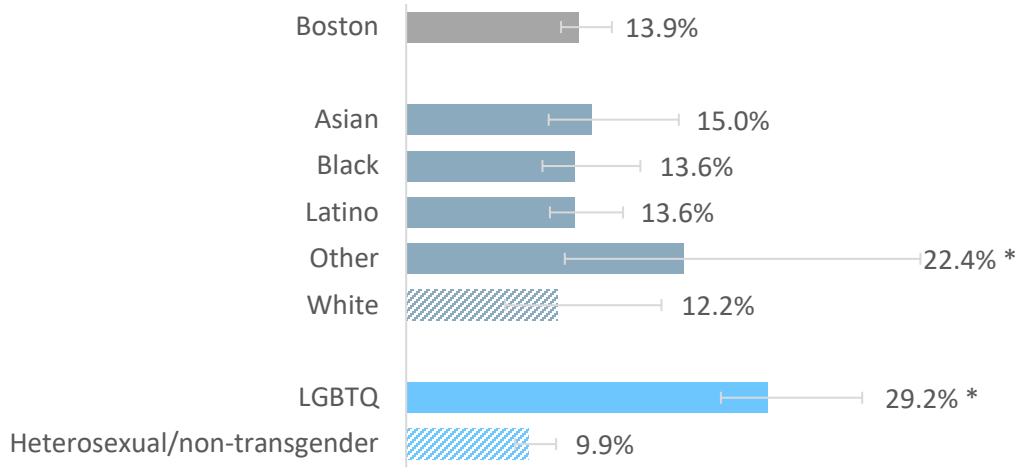
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Persistent anxiety is defined as feeling nervous, anxious or on the edge for more than half of the days within the past 2 weeks; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

Prior to the pandemic, mental health among youth was a concern. Pre-pandemic, about 13.9% of Boston high school students reported having had suicidal thoughts, according to 2015-2019 data from the YRBS. About 29.2% of LGBTQIA+ students reported having had suicidal thoughts, based on the YRBS (Figure 16).

Focus group and interview participants discussed that they were especially concerned about mental health worsening among youth during the pandemic. Youth focus group members cited insufficient sleep, family issues, unhealthy relationships, the stress of school, busy schedules that make it difficult to practice self-care, peer pressure, and unhealthy coping mechanisms as factors that affect their mental health.

Several interviews and focus group discussions emphasized the impact of the COVID-19 pandemic on children and youth, including the disruption of their routines and trauma, despair, adverse childhood experiences, overcrowded housing, and addiction. Youth described being exposed to toxic environments at home during stay-at-home phase of the COVID-19 pandemic. The well-being of adults who support youth also emerged as a concern, including caregivers who have taken care of others during the COVID-19 pandemic and have not have the opportunity to also care for themselves and teachers and school staff who respond to behavioral health issues in school settings.

Figure 16. Percent Boston Public High School Students Reporting Having Suicidal Thoughts, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



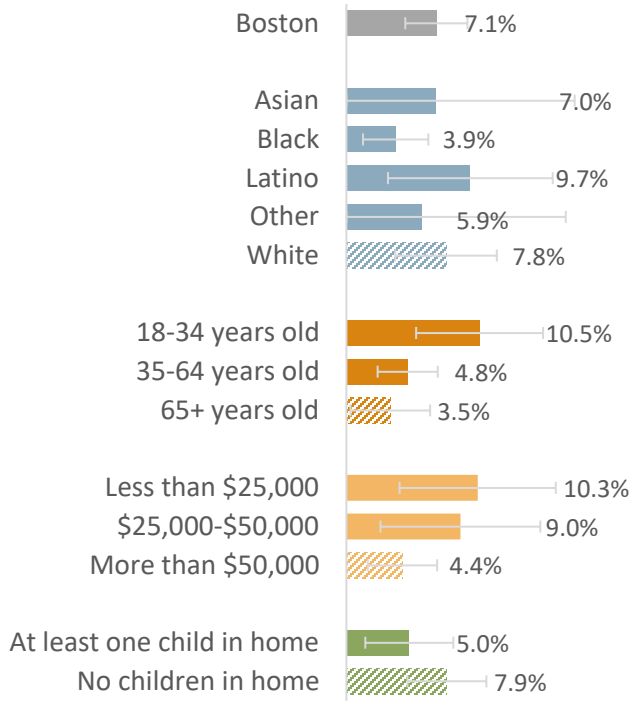
DATA SOURCE: Centers for Disease Control and Prevention and Boston Public Schools, Youth Risk Behavior Survey, 2015, 2017, and 2019 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTE: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

Behavioral and Mental Health Care Access and Barriers to Care

Based on the COVID-19 Health Equity Survey, 9.9% of Boston adults reported delaying mental health care due to the pandemic (see Appendix F for data tables), and about 7.1% reported delaying mental health care specifically because of cost (Figure 17).

Participants discussed several barriers to accessing mental health care. On the supply and demand side, community leaders and residents in interviews and focus groups observed a limited number of mental health providers in the community and in school settings, long wait lists, and few mental health services for children. One provider noted that behavioral health referrals were at the highest level that they could recall. Financial barriers to mental health care identified by key informants and focus group participants included bureaucratic barriers, such as needing a referral from a primary care provider, and limited mental health options for low-income communities. Several focus group participants described a lack of culturally appropriate and linguistically congruent care for low-income residents, residents of color, and LGBTQIA+ residents. Some focus group participants discussed stigma surrounding mental health care, particularly for immigrant communities, communities of color, and youth. As one resident noted, *"They think asking for help is a weakness, not a strength."*

Figure 17. Percent Adults Reporting Not Seeking Mental Health Care Due to Cost During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting there was a time when they needed to see a mental health professional but could not because of cost since March 1, 2020; Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Substance Use

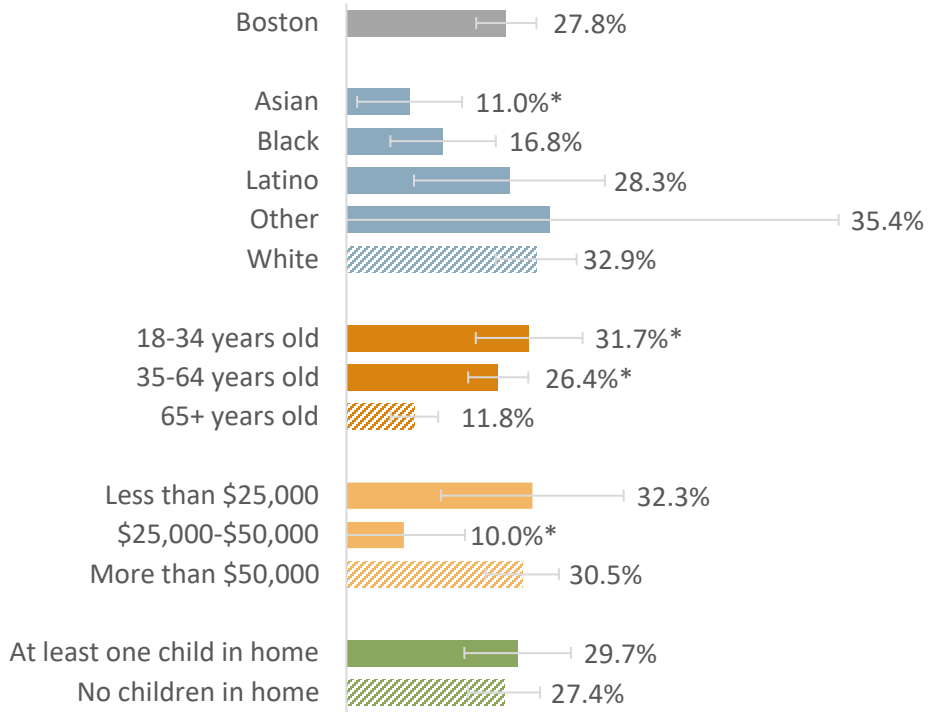
While substance use emerged as a key concern among Boston residents prior to the pandemic, substance use was less commonly discussed as a health concern in recent focus groups and interviews perhaps because residents largely discussed how the COVID-19 pandemic worsened inequities in the social determinants of health. However, mortality data continues to indicate that overdose deaths are an important health issue. In the 2019 community health needs assessment, unintentional opioid overdoses accounted for the majority of deaths due to accidents in 2016. In 2020-2021, the unintentional opioid overdose mortality rate was highest in Dorchester (all zip codes), Roxbury, and the South End (Figure 75 in Appendix F). The unintentional opioid overdose mortality rate for Black and Latino residents exceeded that for White residents in 2020-2021 (Figure 76 in Appendix F). Additionally, the unintentional opioid overdose death rate among Black residents was 50.7 per 100,000 residents in 2020-2021 whereas it was 21.1 per 100,000 residents in 2016. The difference was much less stark for Latino and White residents over this time period.

Some focus group participants discussed substance use concerns, including misuse of drugs, overusing prescriptions and over-the-counter medicines, and smoking nicotine and marijuana. Residents discussed substance use concerns as particularly affecting LGBTQIA+ residents and youth, and described substance use as a coping mechanism for dealing with stress. Several participants perceived that substance use was increasing, particularly among Cape Verdean, Asian, and Vietnamese communities. As one

participant described, *"I can remember as a child how it was; it was a close-knit community. When drugs started being introduced to [our] community, the children dropping out of school, it started to change."*

According to the COVID-19 Health Equity Survey, about 27.8% of Boston adults reported increased drinking habits during the COVID-19 pandemic (Figure 18). Almost 1 in 3 adults 18-34 years of age and over 1 in 4 of adults 35-64 years of age reported increased drinking during the COVID-19 pandemic, compared to 11.8% of adults 65 years of age or over.

Figure 18. Percent Adults Reporting Increased Drinking Habits During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Increased drinking habits is defined as increased weekly alcohol intake or started drinking and did not before since March 1, 2020; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

CHIP PRIORITY AREA - ACCESSING SERVICES: CHILDCARE, SOCIAL SERVICES, AND HEALTH CARE

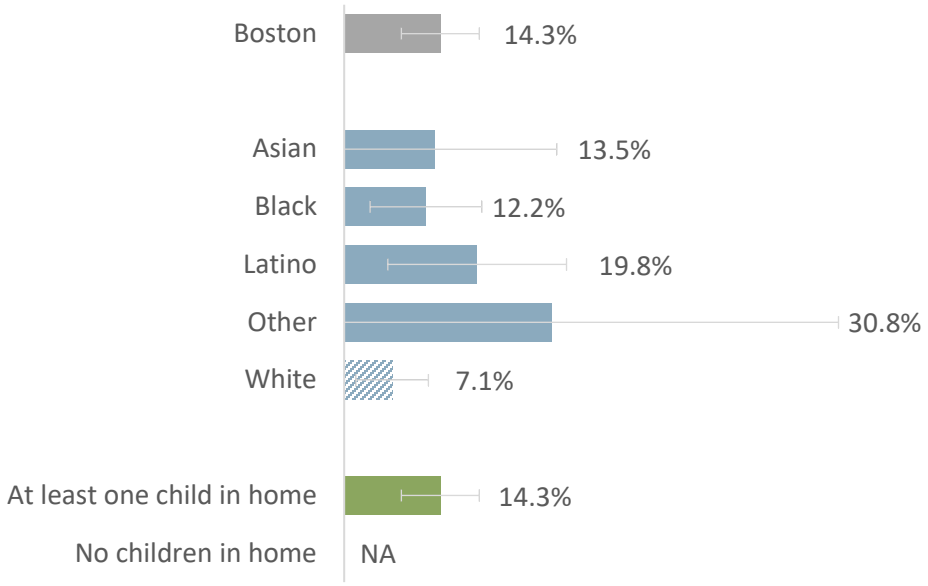
Residents and community leaders continued to cite numerous barriers to accessing childcare, social services, and health care including cost, transportation, language barriers, limited Internet, discrimination and systemic racism, immigration/documentation status, limited culturally appropriate services, and the difficulties in navigating the complex social service and health care systems.

Accessing childcare, social services, and health care was identified as a prominent theme and priority area in the previous community health needs assessment and improvement plan. Some aspect of access limitations came up in nearly every conversation in this recent process, and many issues were exacerbated during the pandemic.

Accessing Childcare Services

Pre-pandemic, Boston residents identified economic and access barriers to affording childcare, and in recent focus groups and interviews childcare emerged as a growing need due to the COVID-19 pandemic. While focus group participants and key informants described several community-based organizations that provide services for historically marginalized groups, they also observed rising and acute social and economic needs among a growing segment of low-income residents. Affordable, quality childcare was difficult to find before the pandemic, but with parents' unpredictable work schedules, unforeseen childcare closings, and the need for many parents to work outside the home, finding care for young children was even more challenging during the pandemic. According to the COVID-19 Health Equity Survey, about 50.1% of adults with at least one child at home indicated that they worked outside the home during the COVID-19 pandemic (see Appendix F for data tables). In the same survey, 14.3% of Boston adults reported that children in their households experienced unmet childcare needs during the pandemic (Figure 19).

Figure 19. Percent Adults with Children Reporting Having Unmet Childcare Needs During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: NA denotes where data are not available because only respondents who indicated having at least one child present in the household were asked this question; Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Some focus group participants and key informants discussed how some students have not been adequately challenged academically or able to reach their full potential during their schooling during the COVID-19 pandemic. Focus group participants and key informants also discussed significant and growing social and emotional needs for children and teens since the onset of the pandemic, particularly low-income children and youth. Barriers to early childhood education cited by residents include the costs of early childhood education, restrictions on vouchers for subsidized childcare for low-income families, limited availability of early childhood education centers, and limited understanding of the benefits of early childhood education.

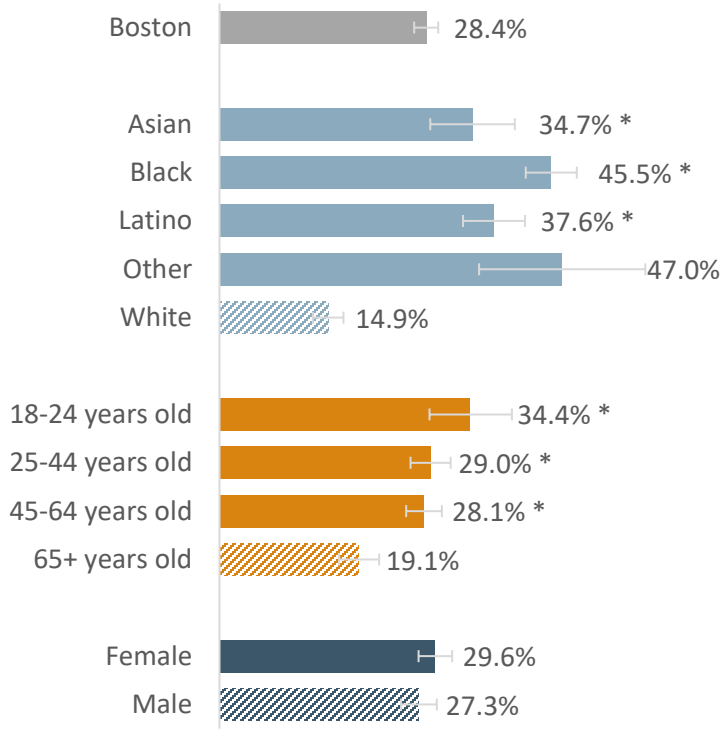
Accessing Social and Other Services

Focus group and interview participants discussed additional challenges of accessing the range of social and other services that might be available. These barriers included limited transportation, difficulty navigating application processes, limited Internet for completing applications, and lack of eligibility due to immigration/documentation status.

A number of participants across conversations also discussed systemic racism, racial injustice, and discrimination as interwoven into U.S. social, economic, educational, and health care systems. Many discussed how our current systems are set up to perpetuate current inequities. Others talked about facing discrimination themselves, in stores, restaurants, employment, or housing. From 2015-2019 BBRFSS data, about 28.4% of Boston residents reported receiving poor service at restaurants or stores in day-to-day life due to their race or ethnicity (Figure 20). About 45.5% of Black adults reported

experiencing poor service, while 37.6% of Latino adults and 34.7% of Asian adults indicated having this experience.

Figure 20. Percent Adults Reporting Receiving Poor Service Due to Their Race/Ethnicity, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting receiving poorer service than other people at restaurants or stores in day-to-day life due to race/ethnicity; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Accessing Health Care Services

Although about 95.8% of Boston residents have health insurance (see Appendix F for detailed data), focus group and interview participants cited numerous barriers to accessing health care services in general and especially during the pandemic.

Overall Barriers to Health Care

Key informants and focus group participants in 2022 cited some very similar barriers to accessing health care as they did in the previous community health needs assessment. Recent focus group participants noted that income-related barriers to accessing care were common and included income restrictions for qualifying for MassHealth, a lack of insurance benefits linked with employment, unaffordable out-of-pocket and surprise medical expenses not covered by health insurance, the high cost of medications (particularly

> *"Due to my language barriers, I was not able to express my health concerns and had a hard time to communicate with doctors to get right treatment."*- Focus group participant

for people with chronic illnesses), and the challenge of finding a job that provides insurance benefits. Participants also discussed distrust towards health care systems and health providers, concern about undocumented legal status, difficulty navigating the health care system, lack of cultural sensitivity among providers, long waits for medical appointments, transportation barriers, and difficulty securing a medical appointment.

Residents shared that language barriers and limited culturally relevant care make it difficult to navigate and access health care and social services and to follow treatment plans for residents for whom English is not their first language. This was particularly salient in conversations with Cape Verdean Creole speakers.

Barriers Specific to People with Disabilities and Older Adults

Some participants described limited staffing and support for home health care as a concern, particularly for older adults and residents with disabilities. Participants with disabilities described several barriers to health care, including: lack of accessible equipment (e.g., exam tables, scales, assistance with wheelchair transfers), communication barriers (e.g., interpretation), the need for support in completing forms, limited training among providers in treating patients with a range of disabilities, denial of access to care (e.g., psychological services, rehabilitation, nursing homes) for people with developmental disabilities, limited information about available resources or services needed, and lack of reliable Internet service.

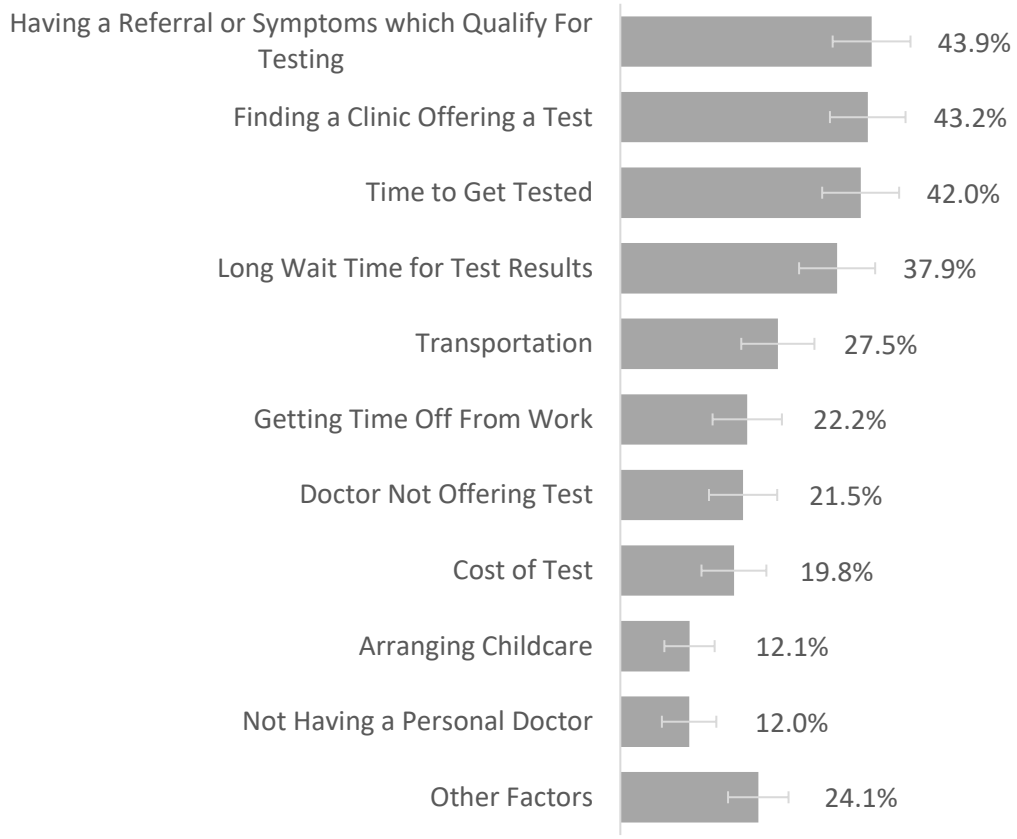
Participants also described a growth in telehealth visits. They noted that conducting assessments and developing treatment plans can be difficult during telehealth visits and that telehealth visits can be a barrier for older adults, immigrants, and persons with disabilities. Participants noted that some patients prefer in-person visits and cited several barriers to using telehealth, including technological resources, support, and training needed.

Health Care Access Specific to the COVID-19 Pandemic

Residents described how racial/ethnic inequities in health care access and social factors that impact health care access – such as transportation and Internet access – have been magnified by the COVID-19 pandemic. Some residents noted that patients who rely on family support for interpretation during visits have lost this support due to COVID-19 policies that limit visits to the patient only. Some key informants and focus group participants discussed how residents with chronic health conditions and those with undiagnosed conditions have been affected by delayed health care and ongoing lack of a medical home.

Getting tested for COVID-19 had its own set of challenges. Respondents of the COVID-19 Health Equity Survey cited a number of barriers to getting tested for COVID-19. Having a referral or symptoms to qualify for a test, finding a clinic that offered COVID testing, the length of time that it takes to get tested, and long wait times to receive COVID test results were the leading barriers to COVID-19 testing among Boston residents in December 2020/January 2021 (Figure 21). However, according to the COVID-19 Health Equity Survey, more than one in five Boston residents also cited issues such as transportation, getting time off of work, and cost of a test as barriers to getting a COVID test in December 2020-January 2021. Appendix F has the breakdown of data by race/ethnicity and age for each of these barriers.

Figure 21. Percent Adults Reporting Barriers to COVID-19 Testing, by Specific Barriers, by Boston and Selected Indicators, 2020-2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Residents explained that at multiple points during the pandemic, COVID-19 information was not clear enough and residents for whom English was not their first language encountered language barriers to accessing changing and time-sensitive COVID-19 information. Lack of access to technology also emerged as a barrier to COVID-19 information, particularly for older adults who relied on family and friends to use technological devices to sign up for COVID-19 resources or access COVID-19 information. Residents also described rampant misinformation about COVID-19.

COMMUNITY'S VISION AND COMMUNITY SUGGESTIONS FOR THE FUTURE

Interview and focus group participants shared numerous ideas for collective action for the future including: addressing systemic racism, strengthening collaboration, improving economic development and housing, improving access to behavioral health and health care services, promoting youth development, and creating a healthier environment.

Deepen Partnerships with Local Communities and Collaborate to Promote Health Equity

While some interviewees described effective collaboration happening throughout the city, they discussed several barriers to collaboration. These challenges included decentralized partnerships and competition for funding among local non-profit organizations, which they noted undermines relationship building. Several interviewees called for creating and strengthening partnerships that create and implement long-term strategic plans to promote community health and developing and deepening long-term relationships between City of Boston agencies (e.g., schools, housing, public health), hospitals, and smaller community-based organizations. To accomplish these goals, key informants recommended centering the voices of affected residents in planning and implementation processes, engaging community builders and community organizers, funding community-based initiatives to implement strategies to address health inequities, and creating centralized mechanisms to share information and resources with residents. Key informants also recommended disseminating CHNAs and CHIPs in modes that improve access to the general public and center resident voices.

> *"[There is opportunity] for closer collaborative work in the city. There is a challenge and advantage of having so many different institutions that are working in the same or overlapping neighborhoods."*– Key informant interview

Focus on Dismantling Systemic Racism

Interview participants' recommendations to address systemic racism included developing hospital-based reparations funds for neighborhoods such as Roxbury, in which hospital campuses are based and which also experience persistent health inequities and developing land trusts that can serve as community spaces. Another recommendation pertained to providing continual education (e.g., Equity, Diversity, and Inclusion training) for institutions and people who work with people of color and low-income communities to improve understanding of and build capacity to address systemic racism and implicit bias. One key informant recommended that schools, businesses, non-profit organizations, governmental, and health care sectors participate in this training.

Create Opportunities that Foster Economic Stability and Mobility

Recommendations for improving employment opportunities included partnering with small businesses to recruit and hire local residents and pay workers a living wage, fostering work environments that are inclusive of LGBTQIA+ communities, and addressing discrimination in hiring and work environments. Additional recommendations included creating opportunities for immigrant health professionals who trained and practiced in their home country to work in the local health care system, improving job training opportunities designed to facilitate economic mobility for youth and

> *"Economic justice goes along with health. To have a healthy community, there's going to be healthy economic activity because it takes psychological, mental, emotional, good way of being for a business to function effectively."* – Key informant interview

adults, and bringing hospitals and community-based organizations together to create health careers training programs for youth.

Strategies to address growing income inequities, as recommended by key informants and interview participants, included containing rising costs, taxing wealthy households and corporations, ensuring residents have life insurance, and forgiving student loans. While several key informants noted that there are several social and economic resources available to support Boston residents, key informants and focus group participants emphasized the importance of connecting residents with these resources and services. Recommendations for supporting immigrants include creating pathways for immigrants to complete any credentialing needed to enable them to work locally, supporting immigrants seeking asylum, and increasing volunteer-based programs to support immigrant communities. Improving resources and services for veterans and LGBTQIA+ communities also emerged as recommendations.

Improve Housing Affordability

Community leaders' and residents' recommendations for promoting housing affordability and stability pertained to improving the availability of low-income housing, increasing access to affordable housing through programs such as rent control and rental assistance, and using vacant buildings as homeless shelters. Another set of recommendations by participants pertained to investing in homeownership models for low-income residents, including asset building programs such as rent-to-own programs for affordable housing and housing loans for low-income residents. Institutionally, one recommendation pertained to ensuring that development projects include credits that are returned to the community to improve housing access and quality.

Improve Access to and Quality of Behavioral Health Care

Recommendations by interview and focus group participants to improve access to mental health care included making therapy accessible to low-income communities and in the primary language of patients; strengthening mental health care in community health centers; improving access to mental health for youth; and increasing awareness about and addressing stigma around mental health services. In terms of improving quality of mental health care, recommendations included increasing culturally congruent care for residents of color and LGBTQIA+ communities; providing peer-to-peer and group therapy models; and incorporating art therapy to engage youth in mental health care. Other recommendations included providing a list of mental health resources that is available in residents' primary language; training community-based stakeholders to respond to mental health crises; and addressing substance use and addiction through mental health care.

> *"We need more mental health services that are not rooted in the white dominant culture, but that are rooted in people's cultural experiences."* – Key informant interview

Strengthen Health Care Policies and Improve Health Care Access and Quality

To improve health care coverage and access, key informants and focus group participants recommended supporting residents in enrolling in MassHealth and other programs for low-income residents such as food and cash aid benefits; lowering health insurance rates; providing access to a wider range of affordable health plans; compensating spouses as personal care assistants under MassHealth; and covering personal protective equipment through health insurance.

Interview and focus group participants also discussed the importance of improving access to preventive and specialty care (e.g., audiology, ophthalmology, podiatry) and collaborating with grassroots organizations when designing efforts to improve health care access. Residents also cited the need to make health care more accessible by providing care in patients' primary language, ensuring that health care is available at times that are feasible for residents who work multiple jobs, addressing transportation barriers to accessing health care. To improve provider sensitivity to patients' needs, residents recommended recruiting more bilingual providers and providers of color to more closely reflect underserved patient populations; training providers to better serve people of color, low-income residents, and people with disabilities; and ensuring providers are connected with the communities they serve.

A recommendation related to the social determinants of health and health care access included providing wrap-around services by addressing multiple health care needs (e.g., preventive care, vaccines). Relatedly, key informants and focus group participants suggested connecting residents with community-based resources in clinic or other community-based (e.g., churches, schools, YMCA) settings located in low-income communities and communities of color. Key informants and focus group participants recommended using this local, centralized setting to connect patients with community resources, leverage medical-legal partnerships to improve residents' access to legal supports, coordinate care for seniors, support the transition from pediatric to adult care, and improve care and support for people with disabilities. One key informant recommended building the capacity of community health workers or other peer-to-peer models to support residents in navigating social and health care systems and to build resident awareness of health issues.

Promote Child and Youth Development

Key informants and focus group participants recommended a number of strategies to promote child and youth development. In the school context, recommendations included providing more funding for schools and creating programs where school nurses provide hygiene kits for students. Another set of recommendations pertained to creating more community-based spaces for youth, such as fully-staffed libraries and community centers, which could provide support with academics, opportunities to be active, workforce development opportunities, connect residents to resources, and bring longstanding and new residents together. Another recommendation included affirming LGBTQIA+ youth. Supporting caregivers and low-income families also emerged as a recommendation, including improving parent supports to access resources and services and navigate educational and criminal justice systems.

Create a Healthier Built and Physical Environment

Having a healthier built and physical environment – built environment, green space, and air quality—was important to focus group and interview participants, and they cited a number of suggestions for the future. Residents described the importance of improving air quality, providing families with air filters, cleaning up vandalism and trash, improving transportation, and providing affordable Internet access and improving digital literacy for low-income residents and older adults. Focus group participants described opportunities for promoting physical activity, such as creating affordable access to gyms, yoga, meditation, and community walks and bike rides. Recommendations for improving access to healthy and affordable food included bringing healthy food to neighborhoods that lack access to healthy, affordable food; improving school lunches to offer healthy, fresh food; and providing nutrition education to LGBTQIA+ communities.

PRIORITIES FOR COLLABORATIVE ACTION

The Boston CHNA-CHIP Collaborative aims to undertake a collaborative planning process May -September 2022 to identify the prioritized issues on which this cross-sector group will take action.

For the past two years, the Boston CHNA-CHIP Collaborative has been focused on four priority areas and implementing the 70 strategies outlined in the 2020 community health improvement plan. Great progress has been made on many of these strategies, while other strategies have not been implemented as extensively given constrained capacity and the current context of the COVID-19 pandemic.

Given this backdrop, the 2022 prioritization process focused on:

1) reaffirming the previous priorities and identifying any new issues that have emerged; and
2) prioritizing specific strategies within these major areas that should be lifted up for future action.

To this end, in May-June 2022, the Collaborative undertook a collaborative prioritization process to solicit community input on the key strategies for collective impact to focus their 2022 community health improvement plan.

Identified and Reaffirmed Priorities

The prioritization process was centered on the data from this 2022 CHNA and the current CHIP which has four main priority areas and an overarching central focus of achieving racial and ethnic health equity:

1: Housing

Focusing on affordability, quality, homelessness, ownership, gentrification and displacement

2: Financial Security and Mobility

Focusing on jobs, employment, income, education, and workforce training which comprised this priority in the past CHIP, and including food security which emerged as a salient issue in the 2022 CHNA

3: Behavioral Health

Focusing on mental health and substance use

4: Accessing Services

Focusing on healthcare, childcare, and social services

Criteria for Prioritization

The Collaborative aimed to use a systemic, engaged approach informed by data to confirm the larger priority areas and prioritize the specific strategies for focus in future planning and implementation efforts. The following criteria were used to help participants identify priority strategies from the current CHIP.

- **Burden:** How much does this issue affect health in Boston?
- **Equity:** Will addressing this issue substantially benefit those most in need?

- **Impact:** Can working on this issue achieve both short-term and long-term change?
- **Feasibility:** Is it possible to address this issue given infrastructure, capacity, and political will?
- **Collaboration/Engagement:** Are there existing groups across sectors willing to work together on this issue? Is there an opportunity for engaging these groups?
- **Data:** Do we have data to support this objective and strategy?

Prioritization Process

The prioritization process was multi-stepped and aimed to be inclusive, participatory, and data driven. During May-June 2022, several steps were taken to confirm the larger priority areas and identify the prioritized strategies for the upcoming planning process. A total of 62 participants were part of the prioritization process, and activities included the following:

- Three separate 90-minute virtual listening sessions were conducted in late May and early June. In each of these sessions, Collaborative members presented key findings and high-level themes from this current CHNA to provide context for prioritization. Following the data presentation, listening session participants (n=15) were asked to complete an online survey to select priority strategies using the criteria described above.

- Based on low participation during the scheduled listening sessions, the survey and a pre-recorded data presentation were sent to all registered participants who did not attend. The survey was open for an additional 24-hours, and an additional 5 respondents completed the prioritization survey.

- To increase participation in the process, Collaborative members attended a Union Capital Boston (UCB) meeting on 6/7/22 to gather additional feedback. 42 community members participated in a break-out session that included a brief data presentation and dialogue about the prioritization process. These participants discussed which areas most resonated with them and provided feedback on which strategies to prioritize.

- Feedback from this session was incorporated with the earlier survey responses, and these results were posted on the Collaborative's website in 10 languages (Arabic, Cape Verdean, Chinese traditional – Cantonese, Chinese simplified – Mandarin, Haitian Creole, Portuguese, Russian, Somali, Spanish, and Vietnamese) to gather additional community input prior to the late June planning session. The feedback form was shared with the Collaborative Steering Committee for distribution to communities via email.

These discussions reaffirmed these four priority areas. The cross-cutting and overarching focus of the planning process will continue to be around ***Achieving Racial and Ethnic Health Equity*** recognizing that institutional racism and structural inequities are what drive the health disparities we see around race, ethnicity, and language in the city for nearly all issues.

The Collaborative will meet to develop a CHIP that will provide a blueprint to address the prioritized strategies listed above. The CHIP development process will include a virtual planning session in late June 2022 to refine the CHIP document based on community input. A 2022 CHIP will be finalized in Fall 2022.

APPENDIX A. STRUCTURE OF THE BOSTON CHNA-CHIP COLLABORATIVE

The Boston CHNA-CHIP Collaborative (the Collaborative) is a group of Boston community residents, community-based organizations, community development corporations, health centers, the hospitals, and the Boston Public Health Commission. This group has come together to achieve sustainable positive change in the health of the city by collaborating with communities, sharing knowledge, aligning resources, and addressing root causes of health inequities. One of the fundamental approaches for this work is to conduct a community health needs assessment so efforts are informed by data and community members themselves. While community health assessment and planning have been long-standing endeavors among organizations across the city, the Collaborative aims to leverage, align, and coordinate efforts and resources across multi-sector stakeholders in Boston. More details about the Collaborative's structure and engagement can be found in the Methods section of this report, Appendices A-C, and at http://www.bostonchna.org/.

The Collaborative's structure provides a framework for large-scale engagement to improve the community's health. This structure includes:

- *Steering Committee* – comprising of 19 members representing hospitals, health centers, Boston Public Health Commission, a public health organization focused on community, community development corporations, and community representatives. Its role is to provide strategic direction and oversight of the process (See Appendix B for list of Steering Committee members).

- *Operations Committee* – comprising of the Steering Committee co-chairs and the Collaborative's Coordinator. This Committee resolves operational issues requiring immediate actions.

- *Work groups* – comprising of Steering Committee members and general membership. The two Work Groups for the CHNA provided input and assistance on implementing activities (See Appendix B for members). For the Boston CHNA, these two Work Groups were:

    - *Community Engagement/Primary Data Work Group* – including 24 members representing a range of organizations, including hospitals, health centers, local public health, community development, and community-based organizations. The Work Group's charge is to provide guidance on the approach to community engagement, input on primary data collections methods, and support with logistics for primary data collection.

    - *Secondary Data Work Group* – including 16 members representing a range of organizations, including hospitals, health centers, and local public health. The Work Group's charge is to provide guidance on secondary data approach and indicators and foster connections with key networks and groups to provide relevant data.

    - *Additional Work Groups* – Additionally, the Collaborative has comprised work groups for the planning and implementation of the Community Health Improvement Plan (CHIP). This includes a work group to prepare for the 2022 CHIP process and four work groups that are focused on overseeing and implementing the strategies of the 2019 CHIP (one per priority area: behavioral health, financial security and mobility, housing, and access to services)

- *General membership* attends events, shares information, and participates in work groups. Over 400 people are engaged in communication with the Collaborative's activities.

APPENDIX B. STEERING COMMITTEE AND WORK GROUP MEMBERS

Boston CHNA-CHIP Collaborative
Steering Committee Membership

Organization	Name
Massachusetts League of Community Health Centers	Mary Ellen McIntyre (co-chair)
Dana-Farber Cancer Institute	Magnolia Contreras (co-chair)
Black Boston COVID-19 Coalition	Louis Elisa
Community Resident	Ricky Guerra
Madison Park Development Corporation	Leslie Reid
Mattapan Food and Fitness Coalition	Vivien Morris
Urban Edge	Emilio Dorcely
Beth Israel Deaconess Medical Center	Nancy Kasen
Boston Children's Hospital	Shari Nethersole, MD
Boston Medical Center	Thea James, MD
Brigham & Women's Hospital	Michelle Keenan
Brigham & Women's Faulkner Hospital	Tracy Mangini Sylven
East Boston Neighborhood Community Health Center	Hollis Graham
Harbor Health Services	Amanda Mastrangelo
Massachusetts General Hospital	Leslie Aldrich
Mass Eye and Ear	Tavinder Phull
Tufts Medical Center	Sherry Dong
Boston Public Health Commission	Catherine Fine

Community Engagement (Primary Data) Work Group Membership
Boston CHNA-CHIP Collaborative

Organization	Name
Beth Israel Deaconess Medical Center	Robert Torres (co-chair)
Jamaica Plain Neighborhood Development Corporation	Ricky Guerra (co-chair)
Mattapan Food and Fitness Coalition	Vivian Morris
Beth Israel Deaconess Medical Center	Danelle Marable
Boston Children's Hospital	Ayesha Cammaerts
Boston Children's Hospital	Carolyn King
Brigham & Women's Hospital	Sarah Ingerman
Brigham & Women's Hospital	Madison Louis
Dana-Farber Cancer Institute	Magnolia Contreras
East Boston Neighborhood Community Health Center	Joanna Cataldo
East Boston Neighborhood Community Health Center	Alexis Davis
East Boston Neighborhood Community Health Center	Gloria DeVine
East Boston Neighborhood Community Health Center	Joanne Suarez
East Boston Neighborhood Community Health Center	Carly Wellington
Mass General Brigham	Tavinder Phull
Massachusetts General Hospital	Leslie Aldrich
Massachusetts General Hospital	Kelly Washburn
Massachusetts League of Community Health Centers	Mary Ellen McIntyre
Tufts Medical Center	Lisa Hy
Tufts Medical Center	Karen Peterson
Tufts Medical Center	Danchen Xu
Boston Public Health Commission	Catherine Fine
Boston Public Health Commission	Trinese Polk
City of Boston Health and Human Services	Krystal Garcia

Secondary Data Work Group Membership
Boston CHNA-CHIP Collaborative

Organization	Name
Mass General Brigham	Trang Hickman (co-chair)
Boston Public Health Commission	Johnna Murphy (co-chair)
Boston Children's Hospital	Ayesha Cammaerts
Boston Children's Hospital	Carolyn King
Brigham & Women's Hospital	Sarah Ingerman
Brigham & Women's Hospital	Madison Louis
Brigham & Women's Hospital	RonAsia Rouse
Dana-Farber Cancer Institute	Magnolia Contreras
Harbor Health Services	Amanda Mastrangelo
Mass General Brigham	Tanner Parente
Mass General Brigham	Tavinder Phull
Massachusetts General Hospital	Nikki Reyes
Tufts Medical Center	Sherry Dong
Tufts Medical Center	Karen Peterson
Boston Public Health Commission	Catherine Fine
City of Boston Health and Human Services	Krystal Garcia

APPENDIX C. ONGOING PARTNER AND COMMUNITY ENGAGEMENT AND THE COLLABORATIVE PROCESS

Ongoing Partner and Community Engagement
Community health improvement efforts can only be accomplished through ongoing and meaningful engagement of community members and partners across a multitude of sectors. Through the work group structure, open community meetings, email dissemination, and the vast network of partners, the Collaborative aims to engage a range of sectors in the community. The Steering Committee of the Collaborative includes local public health, hospitals, community development, health centers, and numerous community organizations. Each Steering Committee member is a champion, engaging a wide network of organizations and residents. Each Collaborative work group comprises dozens of members across sectors to advance their charge. When gaps are identified within the activities of the work groups, work group co-chairs make a concerted effort to engage those involved in that area (e.g., bringing in additional representatives from the childcare sector in Access to Services during the implementation process.)

The community engagement process was carried out in accordance with the Massachusetts Department of Public Health's Community Engagement Standards for Community Health Planning Guideline, consistent with state law, Determination of Need (DoN) Regulation found at 105 CMR 100.000 as well as The Attorney General's Community Benefits Guidelines for Non-Profit Hospitals. These standards establish procedures for defining the community, required stakeholders, and process steps and requirements.

Through email communications, virtual and in-person meetings and listening sessions run by the Collaborative, and meetings via Steering Committee members' own structures (e.g., hospital Community Benefit Advisory Committees), community members have been and will be continuously engaged in this process from assessment to planning to implementation.

This includes inviting broad resident and stakeholder participation in the CHIP Working Groups for each priority area. These CHIP working groups meet monthly or bi-monthly throughout the CHIP implementation period and are led by two Co-Chairs who manage and oversee these meetings. The CHIP Working Group Co-Chairs also update and present to the larger Collaborative Steering Committee at least three times annually and meet as a group six times annually to explore and discuss synergies and cross-collaboration in key CHIP implementation objectives.

At the Collaborative's annual community meeting, the CHIP Working Group Co-Chairs provide updates to the larger community and move into breakout sessions to strategize, strengthen and update CHIP working group activities and objectives, and to recruit new members to the CHIP Working Groups.

Communicating about the Assessment Findings
As mentioned in the Priorities for Collaborative Action section in this report, the CHNA findings were shared with community members in four different listening sessions in May-June 2022. During these sessions, Collaborative members presented on the assessment findings and engaged in a discussion with community members on what resonated with them and where there are gaps to inform a systematic prioritization process for planning. In total, 62 community members participated in this process.

Once this report is final, it will be posted on the Collaborative's website, and an announcement with the link to the report will be emailed out to the Collaborative mailing list, nearly 400 people that comprise of residents and community organization staff from across sectors including housing, transportation, economic development, public health, healthcare, and the faith community.

Continuous Updating and Revising of the Assessment

Review of data is a critical part of the planning and implementation process. The Collaborative has data sharing agreements with the Boston Public Health Commission and strong relationships with institutions and organizations across the city. These institutions are part of the Community Health Improvement Planning (CHIP) implementation work groups. During these work group meetings, data from the specific priority areas will be continuously examined to ensure that strategies are appropriate for and aligned to the community's needs.

In the past cycle, the ongoing CHIP implementation work groups (one per priority area) used the 2019 CHNA data to develop their initial list of strategies. In 2020 and on, they continually worked with the Boston Public Health Commission and community-based organizations to collect and synthesize new data, particularly with a focus on how the COVID-19 pandemic exacerbated inequities and identified areas of urgent need. For example, during the process, real-time data indicated that many residents were facing a loss of income, increased risk of eviction, and loss of childcare during the pandemic. This guided the CHIP implementation work groups so that they could nimbly adjust to current circumstances: the Financial Security and Mobility group focused more on employment-related strategies, the Housing work group focused more on eviction issues, and the Access to Services ramped up their strategies addressing childcare needs. This was only made possible via the broad cross-section of partnerships within each work group. These issue areas were identified as critical for further review during the 2022 CHNA process.

In addition to carrying forward the foregoing processes into the next cycle, the Collaborative plans to hold annual community meetings in order to provide updates to the community on CHIP progress and objectives, and to gain additional input and recommendations from Community Members on current and future activity within each working group. The Collaborative has held annual community meetings each year, with the exception of 2021 when virtually all Collaborative members shifted to responding to a significant surge in community transmission of COVID-19 and increased hospitalizations.

As new data and community input is generated and synthesized through these processes, it will also be reviewed at least annually for the purposes of identifying any potential enhancements or additions to the CHNA.

APPENDIX D. TECHNICAL NOTES ON CHNA QUANTITATIVE AND QUALITATIVE METHODS AND DATA

Quantitative Data – Secondary Data

How Indicators and Data Sources were Identified

The Secondary Data Work Group members identified the goals of the secondary data as: 1) to examine inequities by population group specifically among those with disproportionate burden and 2) to dig deeply into areas of need most exacerbated by the COVID-19 pandemic.

The Secondary Data Work Group was instrumental in developing and providing feedback on list of data indicators, identifying potential data sources, and making connections to those sources. The secondary data work group began their work of reviewing the indicator list from the 2019 CHNA. These indicators were identified through multiple methods – 1) review of existing, validated indicators for social, economic, and health issues; 2) multiple discussions with a 30 person secondary data work group to brainstorm gaps in the initial list: and 3) review and refinement of the longer indicator list among the work group and work group co-chairs to prioritize those indicators that were available, focused on upstream issues, could be tracked over time, and where there were significant inequities.

The 2022 CHNA process started with this 2019 list and then further refined and prioritized for this report. The secondary data work group engaged in multiple discussions and prioritized indicators: that aligned with the 2019 priority areas; that COVID-19 had a disproportionate impact on, and/or where there were the greatest inequities by race/ethnicity, neighborhood, or other characteristics.

Secondary Data Sources

Numerous data sources were reviewed and included in the 2022 CHNA. Secondary data sources included U.S. Census/American Community Survey, vital statistics (birth/death records), hospital case mix data, Bureau of Labor Statistics, Boston Behavioral Risk Factor Surveillance Survey (BBRFSS), BBRFSS COVID-19 Health Equity Survey, Youth Risk Behavior Survey (YRBS), and the Massachusetts Department of Public Health Bureau of Substance Addiction Services treatment data.

Analyses

All secondary data on birth and death records, BBRFSS, YRBS, and Acute Hospital Case Mix were analyzed by the Research and Evaluation Office of the Boston Public Health Commission. Other data were analyzed by the organizations cited in the data source. Analyses were conducted for frequencies (percentages) and rates (per 100,000 residents), where applicable. Confidence intervals (or error bars in the figures) were calculated for survey data from the ACS and surveillance systems, such as the BBRFSS and YRBS. Statistical significance testing by sub-groups was conducted at $p<0.05$.

Secondary data were included in the main body of the CHNA report that were most relevant to the themes that emerged in the focus groups and interviews, that aligned with the CHIP priority areas, that COVID-19 had a disproportionate impact on, and where there were the most significant inequities by race/ethnicity, neighborhood, or other characteristics

Qualitative Data – Focus Groups and Interviews

How Populations and Interviewees were Identified

The Community Engagement Work Group identified one of its main goals as ensuring that diverse and historically underrepresented community voices are lifted throughout the CHNA-CHIP process using an equity framework. To that end, the Community Engagement work group conducted a thorough review of the 2019 CHNA and identified areas where there were gaps in representation. Concerted efforts were made in the 2022 process to ensure that those voices were included (e.g., expanded engagement with residents of Chinatown and Boston's Chinese community.)

Additionally, each hospital involved their Community Benefit Advisory Committee (CBAC) in the process as well, which included engagement of stakeholders at the neighborhood level across a range of sectors. The list of population segments for focus groups and stakeholders were vetted through each CBAC and additional ideas were brainstormed where there were gaps. CBACs were also asked to identify neighborhoods and population segments most impacted by COVID-19 (e.g., essential workers).

Focus group discussions were conducted with those who have been disproportionately burdened by social, economic, and health challenges including: youth and adolescents, older adults, persons with disabilities, low-resourced individuals and families, LGBTQI+ populations, racially/ethnically diverse populations and/or limited-English speakers (e.g., African American, Latino, Haitian, Cape Verdean, Vietnamese, Chinese), immigrant and asylee communities, families affected by incarceration and/or violence, and veterans. Key informant interviews were conducted with a cross-section of sectors to identify areas of action and perspectives on the community. These interviewees included leaders and staff from public health, health care, behavioral health, the faith community, immigrant services, housing organizations, economic development, community development, racial justice organizations, social service organizations, education, community coalitions, the business community, childcare centers, elected government offices, and others.

Discussion Guides and Process

Members of the Community Engagement Work Group and their partners -- Boston Children's Hospital, John Snow Inc. on behalf of Beth Israel Medical Center and New England Baptist Hospital, Massachusetts General Hospital, Brigham and Women's Hospital, Brigham and Women's Hospital Faulkner Hospital, Tufts Medical Center, East Boston Neighborhood Health Center, EASTIE Coalition at East Boston Neighborhood Center, Soccer without Borders, Veronica Robles Cultural Center, and Maverick Landing Community Services – conducted the focus groups and interviews. Members of the community engagement work group divvied up key informant interviews and focus groups that they conducted using a consistent guide which focused on community needs and strengths and particularly which aspects of life were most impacted by the pandemic. Each organization organized their own discussions and made slight variations to the guide where appropriate.

Qualitative data were from 62 key informant community leaders across a range of sectors and 29 focus groups with 309 community residents. The selection process for both the qualitative and quantitative data were guided by the Collaborative's shared values of equity.

Analysis

Each organization that conducted the focus groups and interviews initially synthesized the data they collected. The organizations summarized key themes into a consistent template that identified

feedback from the discussions on the community strengths, impact of COVID, priority health issues, factors that promote community health, barriers to healthy living, specific findings among the four priority areas (housing, financial security and mobility, behavioral health, and accessing services), and proposed ideas and recommendations for the future. Findings under each of these were summarized, along with notations among which sub-populations they mapped to. Additionally, the template provided space for organizations to pull out illustrative quotes.

These summaries were submitted to Health Resources in Action (HRiA), a non-profit public health organization, that helped support the analysis and development of the CHNA report. HRiA analyzed the qualitative summaries to identify common themes across population groups as well as unique challenges and perspectives identified by populations and sectors, with an emphasis on diving deep into the root causes of inequities. Frequency and intensity were key factors used for extracting main themes and sub-themes, as well as its alignment with the Collaborative's focus on equity.

Asset Mapping and Community Resources

Leading up to the 2022 CHNA, most of the CHIP work groups (one per priority area: behavioral health, access to services, housing, and financial stability & mobility) developed a comprehensive resources list to identify where there were current resources and where there were gaps. This information guided which strategies were prioritized, how they were implemented, and which partners needed to be involved in the discussions. This information then informed the 2022 CHNA. Additionally, in the 2022 CHNA, 62 key informant community leaders in interviews and 309 community residents in 29 focus groups were asked about what they saw as the strengths and assets in their community. This feedback was synthesized in this report.

APPENDIX E. KEY INFORMANT INTERVIEWEE ORGANIZATIONS

Organization
Alice Taylor Housing
Black Ministerial Alliance TenPoint
Boston Center for Independent Living
Boston City Council
Boston Higher Education Resource Center
Boston Housing Authority
Boston Police Community Liaison
Boston Police Department
Boston Public Health Commission
Boston Public Schools
Boston Senior Home Care
Boston Women's Fund
Boys & Girls Club of Boston
Brigham and Women's Hospital
Cape Verdean Association of Boston
Cape Verdean Community Leader
Community Servings
Dimock Center
East Boston Neighborhood Health Center
East Boston Social Centers
Ecumenical Social Action Committee Boston
Family Nurturing Center
Fenway Health
Friends of the Boston Public Library
Greater Boston Parents, Families, and Friends of Lesbians and Gays
Haitian Americans United
Haitian Community Leader
Health Leads Boston
Hyde Park Community Physicians
Italian Home for Children
Jamaica Plain Neighborhood Development Corporation
Local Initiatives Support Corporation
Madison Park Development Corporation
Madison Park High School
Maria Sanchez House
Massachusetts Affordable Housing Alliance
Massachusetts Association of Community Development Corporations
Massachusetts General Hospital Asylum Clinic
Massachusetts Office on Disability
Massachusetts State Legislature
Maverick Landing Community Services
Metropolitan Area Planning Council
Mission Hill Health Movement

Mission Hill Link
Mission Hill Main Streets
Mission Hill Neighborhood Housing Services
Mission Main
NAACP
Parker Hill Fenway
Partners for Youth with Disabilities
Roxbury Main Streets
Roxbury Tenants of Harvard
Sociedad Latina
South Cove Community Health Center
Tech Goes Home
Tobin Community Center
YMCA Hyde Park

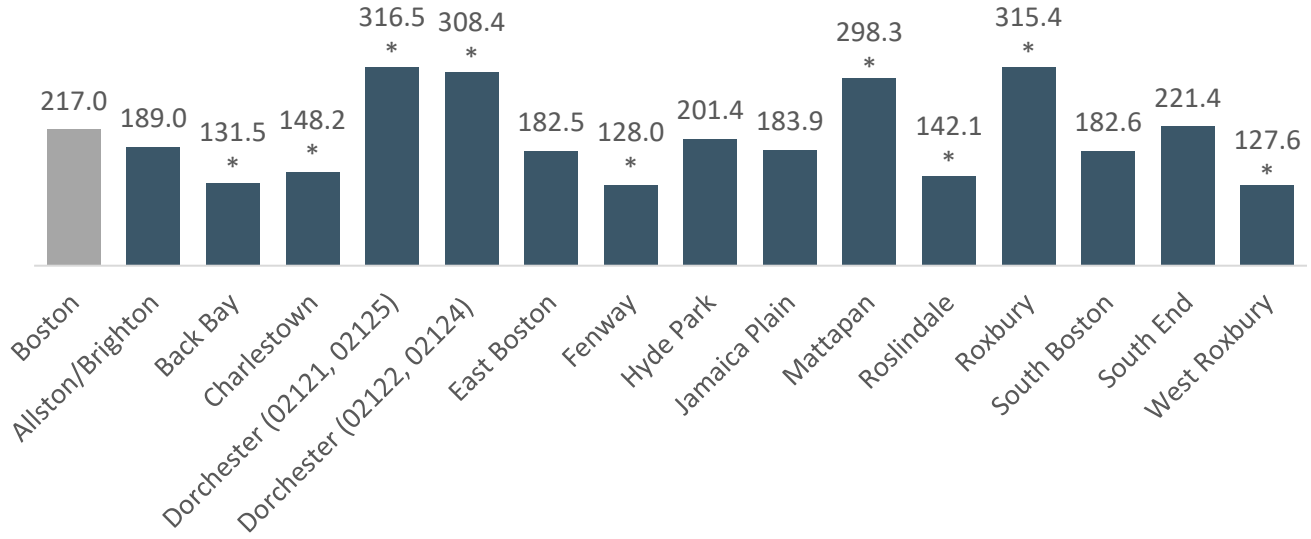
APPENDIX F. ADDITIONAL DATA TABLES

The main CHNA report focused on including data that were most relevant to the themes that emerged in the focus groups and interviews, that aligned with the CHIP priority areas, that COVID-19 had a disproportionate impact on, and where there were the most significant inequities by race/ethnicity, neighborhood, or other characteristics. Appendix F includes additional data to complement what is presented in the body of the report.

Community Health

Premature Mortality

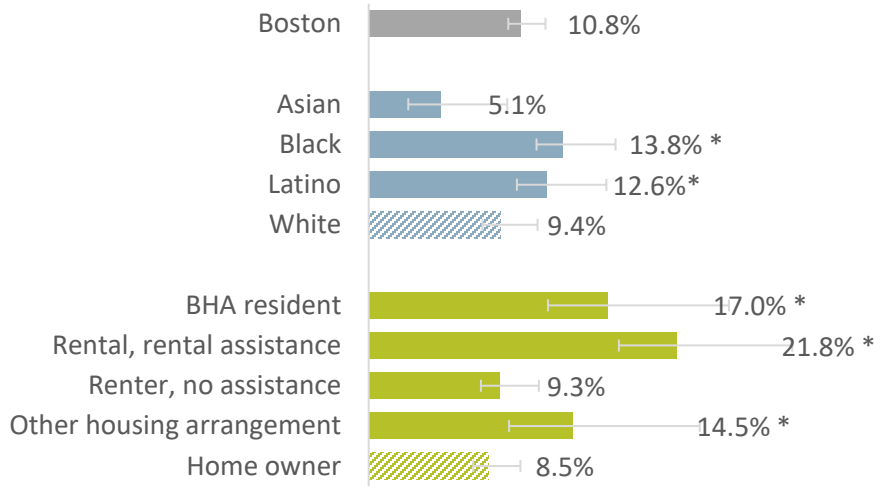
Figure 22. Premature Mortality Rate, by Boston and Neighborhood, Age-Adjusted Rate per 100,000 Residents, 2020-2021 Combined



DATA SOURCE: Boston Public Health Commission, Boston resident deaths, 2020-2021 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Premature deaths are defined as deaths at an age under 65 years; Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Massachusetts Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$)

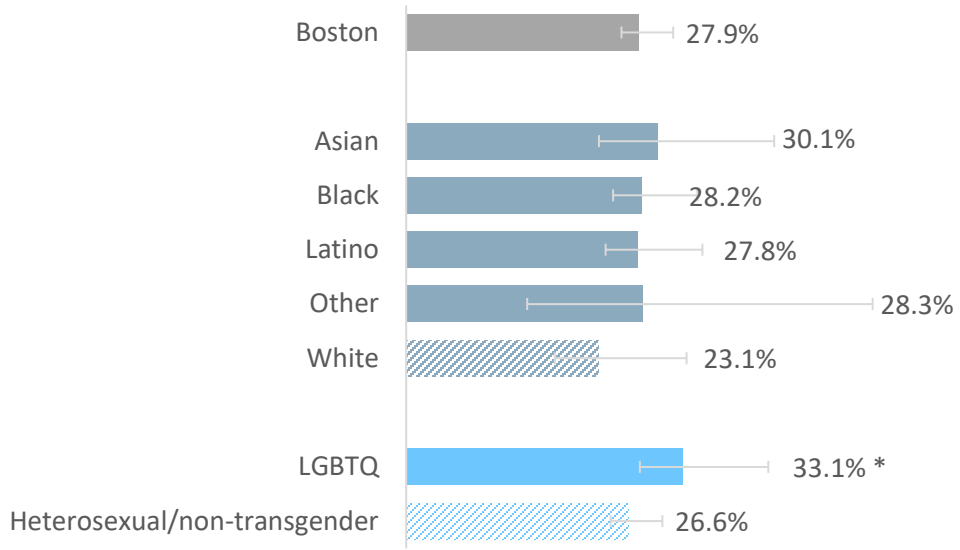
Asthma

Figure 23. Percent Adults Reporting Having Asthma, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



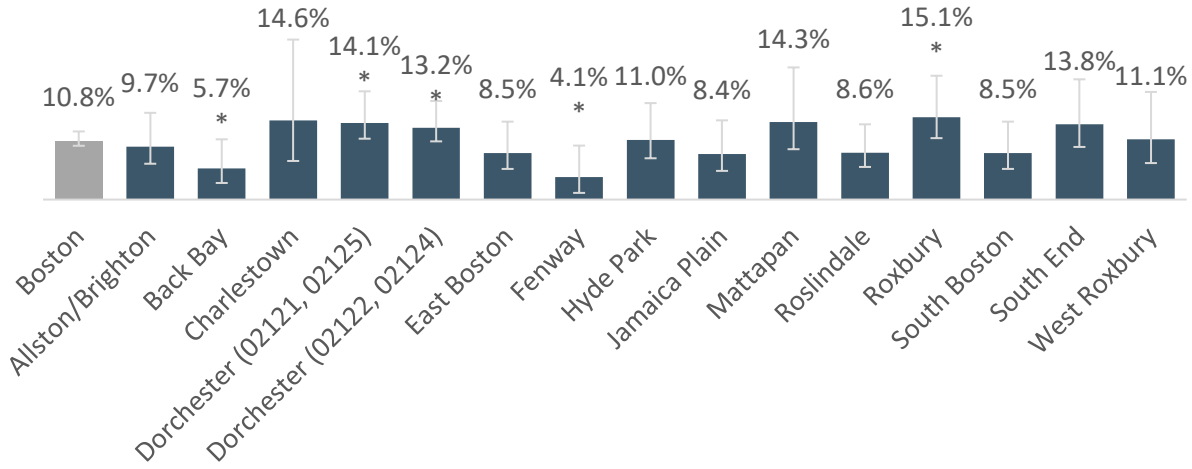
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 24. Percent Boston Public High School Students Reporting Having Asthma, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



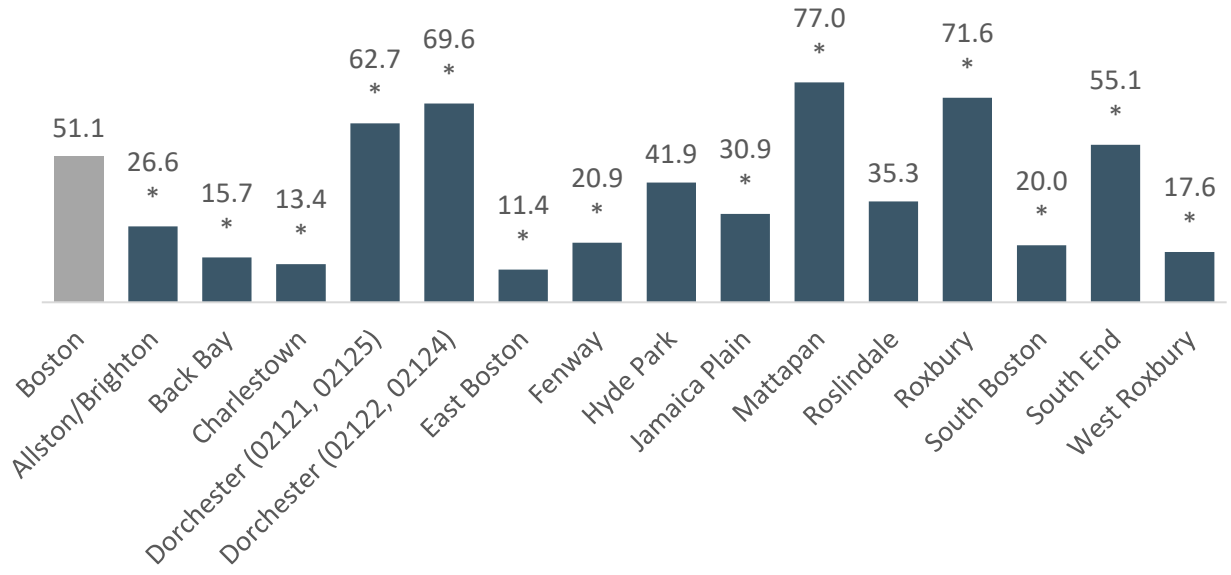
DATA SOURCE: Centers for Disease Control and Prevention and Boston Public Schools, Youth Risk Behavior Survey, 2015, 2017, and 2019 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTE: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 25. Percent Adults Reporting Having Asthma, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



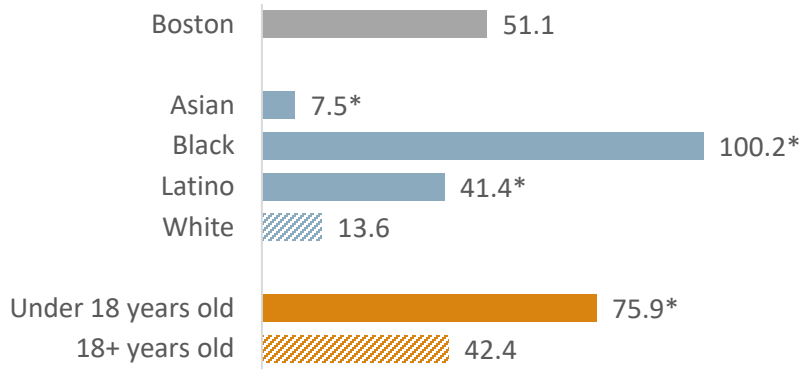
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 26. Asthma-Related Hospital Patient Encounter Rate, by Boston and Neighborhood, Age-Adjusted Rate per 10,000 Residents, 2020



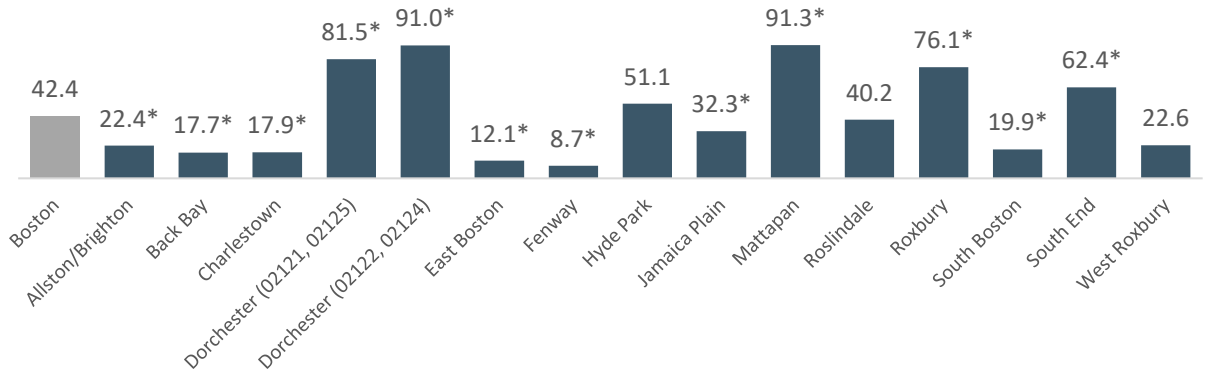
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTE: Hospital patient encounters (HPEs) include both emergency department visits and hospitalizations; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

Figure 27. Asthma-Related Hospital Patient Encounter Rate, by Boston and Selected Indicators, Age-Adjusted Rate per 10,000 Residents, 2020



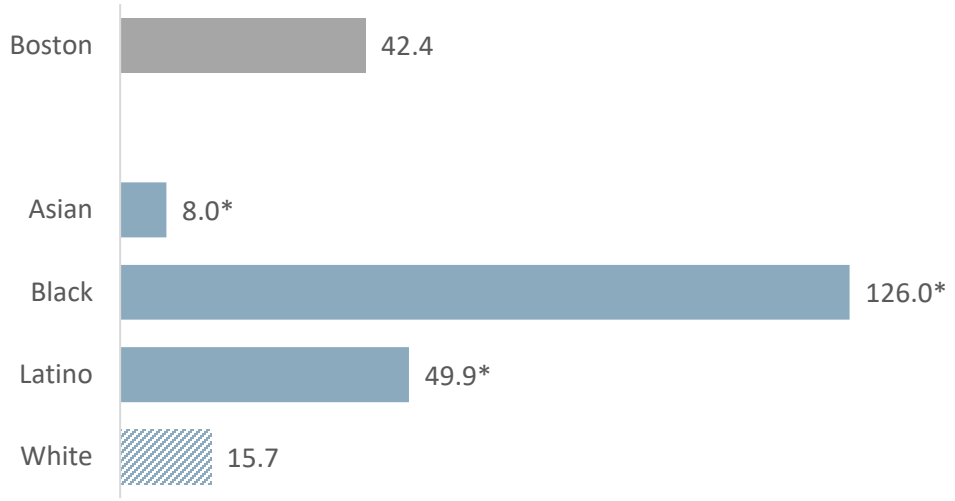
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTE: Hospital patient encounters (HPEs) include both emergency department visits and hospitalizations. Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

Figure 28. Asthma Hospital Patient Encounters (Adults Over 18 Years), by Boston and Neighborhood, Rate per 10,000 Residents, 2020



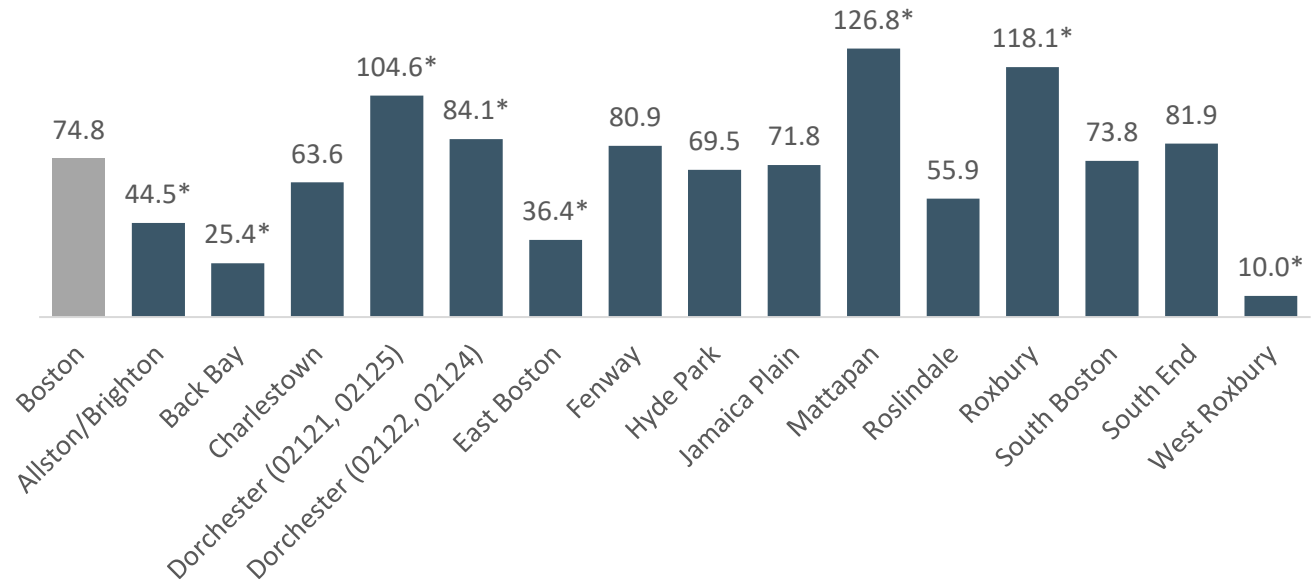
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Hospital patient encounters (HPEs) include both emergency department visits and hospitalizations; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

Figure 29. Asthma Hospital Patient Encounters (Adults Over 18 Years), by Boston and Race/Ethnicity, Rate per 10,000 Residents, 2020



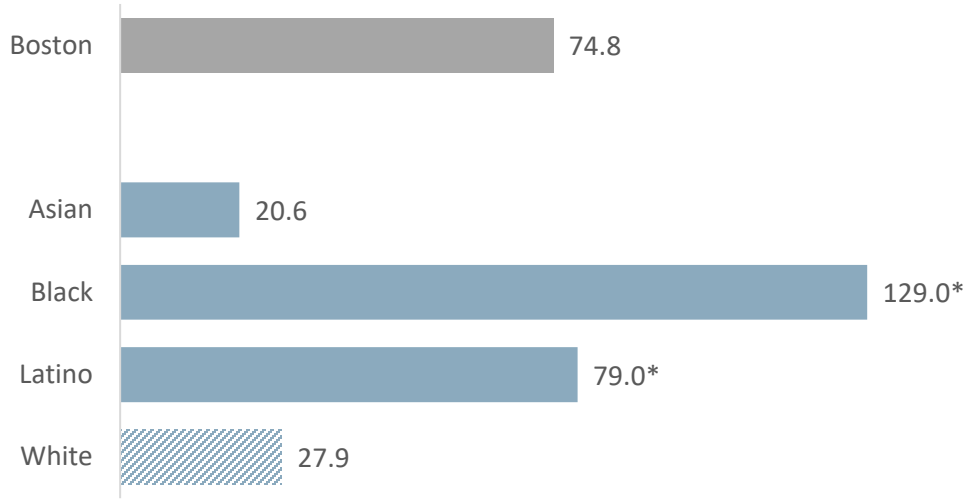
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Hospital patient encounters (HPEs) include both emergency department visits and hospitalizations; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

Figure 30. Asthma Hospital Patient Encounters (Children Under 18 Years), by Boston and Neighborhood, Rate per 10,000 Residents, 2020



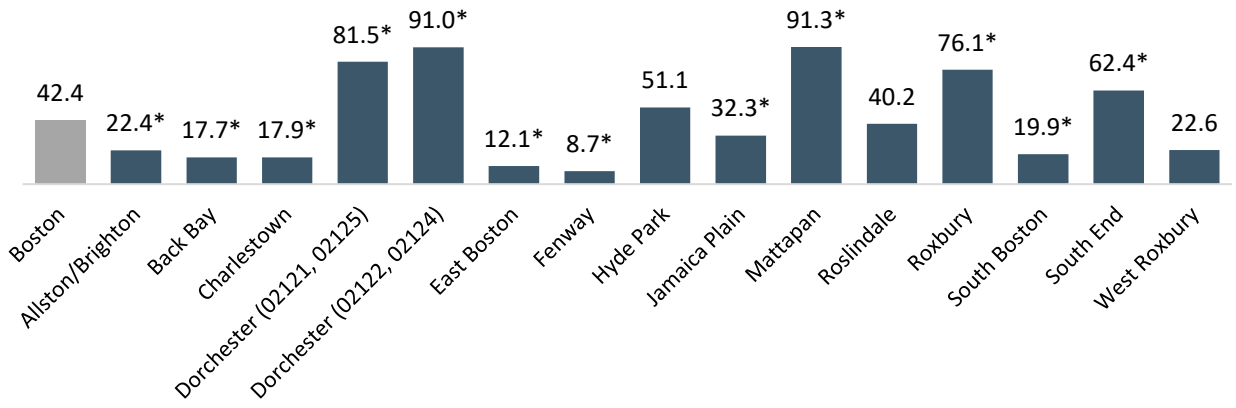
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Hospital patient encounters (HPEs) include both emergency department visits and hospitalizations; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

Figure 31. Asthma Hospital Patient Encounters (Children Under 18 Years), by Boston and Race/Ethnicity, Rate per 10,000 Residents, 2020



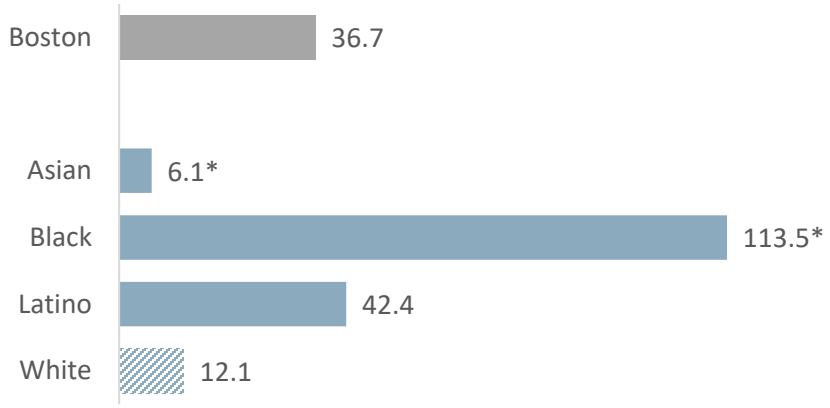
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Hospital patient encounters (HPEs) include both emergency department visits and hospitalizations; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

Figure 32. Asthma Emergency Department Visits (Adults Over 18 Years), by Boston and Neighborhood, Rate per 10,000 Residents, 2020



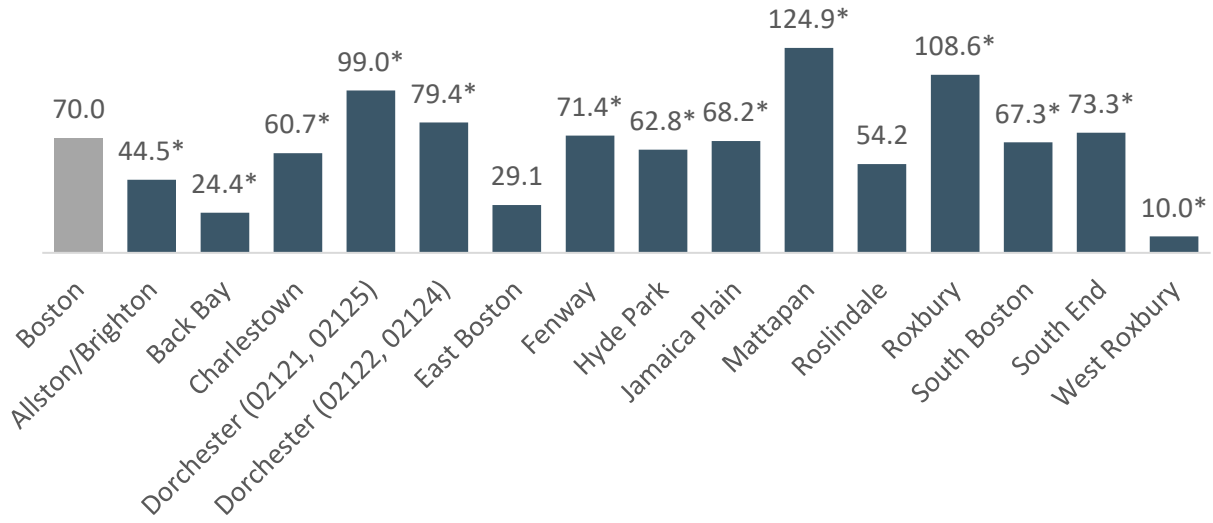
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

Figure 33. Asthma Emergency Department Visits (Adults Over 18 Years), by Boston and Race/Ethnicity, Rate per 10,000 Residents, 2020



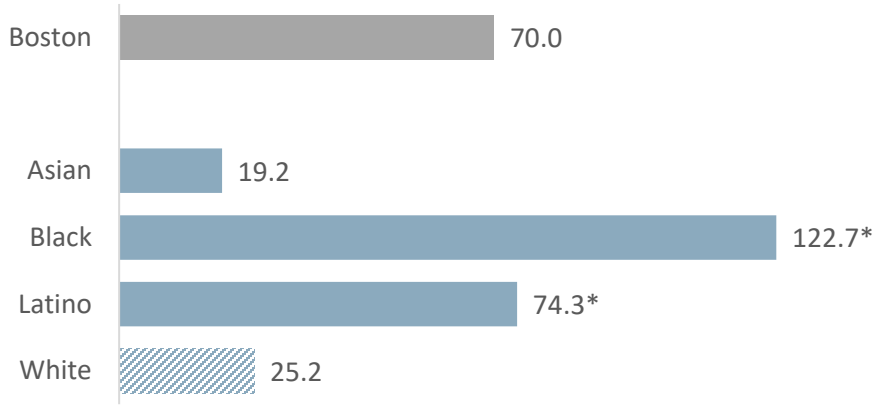
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

Figure 34. Asthma Emergency Department Visits (Children Under 18 Years), by Boston and Neighborhood, Rate per 10,000 Residents, 2020



DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

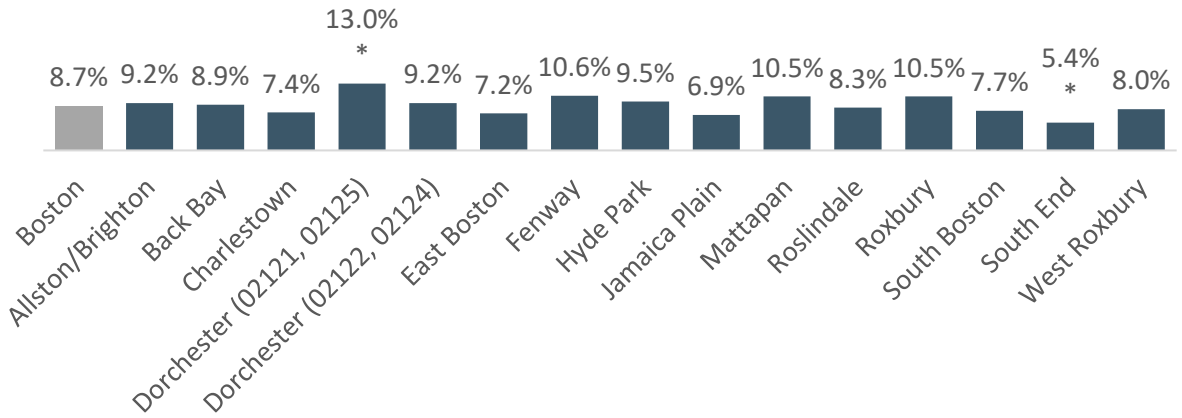
Figure 35. Asthma Emergency Department Visits (Children Under 18 Years), by Boston and Race/Ethnicity, Rate per 10,000 Residents, 2020



DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

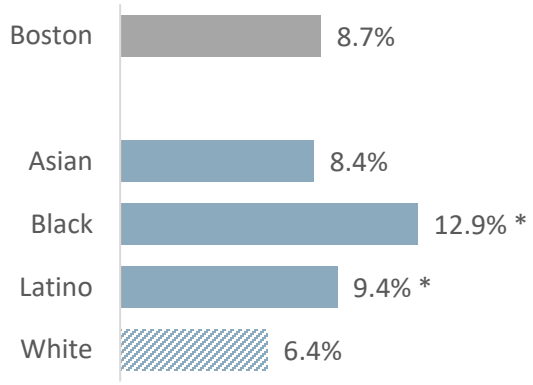
Birth Outcomes

Figure 36. Percent Low Birthweight Births, by Boston and Neighborhood, 2019



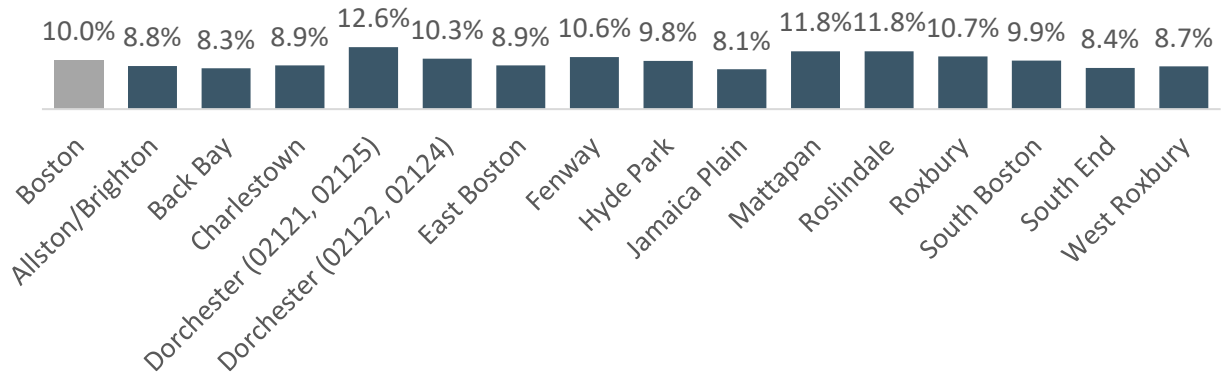
DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Live Births, 2019
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Low birthweight is defined as weighing less than 5 pounds, 8 ounces; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

Figure 37. Percent Low Birthweight Births, by Boston and Race/Ethnicity, 2019



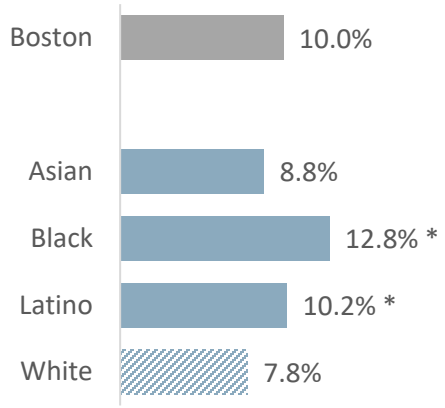
DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Live Births, 2019
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Low birthweight is defined as weighing less than 5 pounds, 8 ounces; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

Figure 38. Percent Preterm Births, by Boston and Neighborhood, 2019



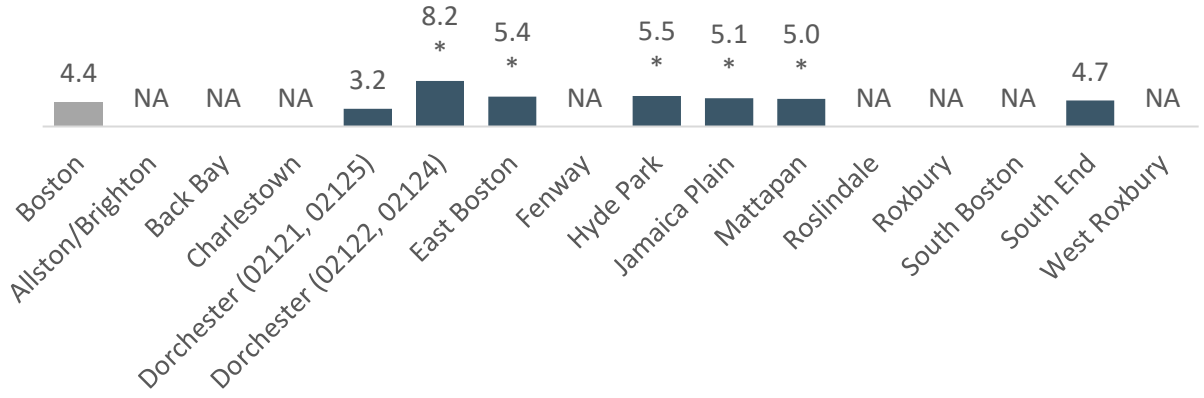
DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Live Births, 2019
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Preterm birth is defined as being born before 37 weeks of gestation; No significant differences between neighborhood estimates compared to the rest of Boston were observed (p>0.05)

Figure 39. Percent Preterm Births, by Boston and Race/Ethnicity, 2019



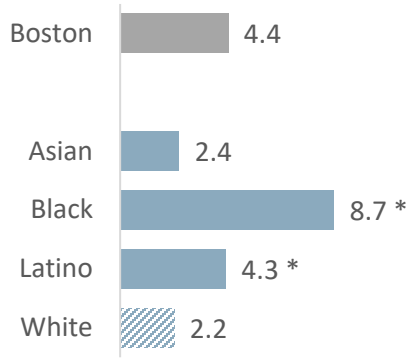
DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Live Births, 2019
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Preterm birth is defined as being born before 37 weeks of gestation; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

Figure 40. Infant Mortality Rate, by Boston and Neighborhood, Rate per 1,000 Live Births, 2017-2019 Combined



DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Live Births, 2017-2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Infant mortality is defined as the death of an infant before 1 year of age; NA denotes where rates are not shown due to insufficient sample size; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

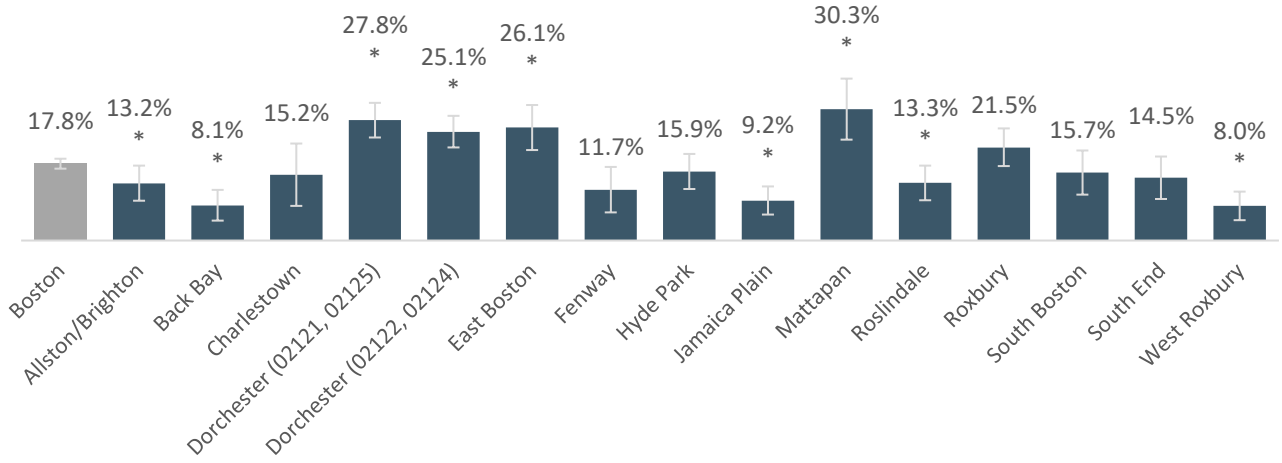
Figure 41. Infant Mortality Rate, by Boston and Race/Ethnicity, Rate per 1,000 Live Births, 2017-2019 Combined



DATA SOURCE: Massachusetts Department of Public Health, Boston Resident Live Births, 2017-2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Infant mortality is defined as the death of an infant before 1 year of age; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

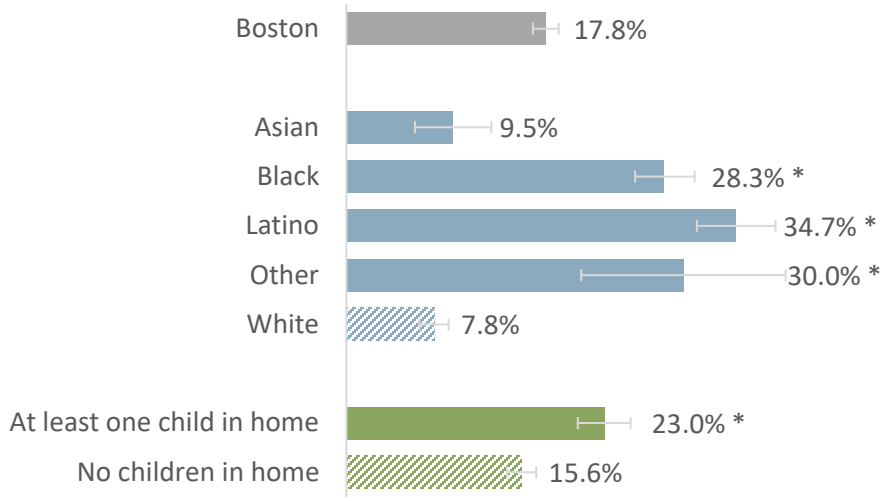
Financial Security and Mobility

Figure 42. Percent Adults Reporting Food Purchased Did Not Last and Did Not Have Money to Get More, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



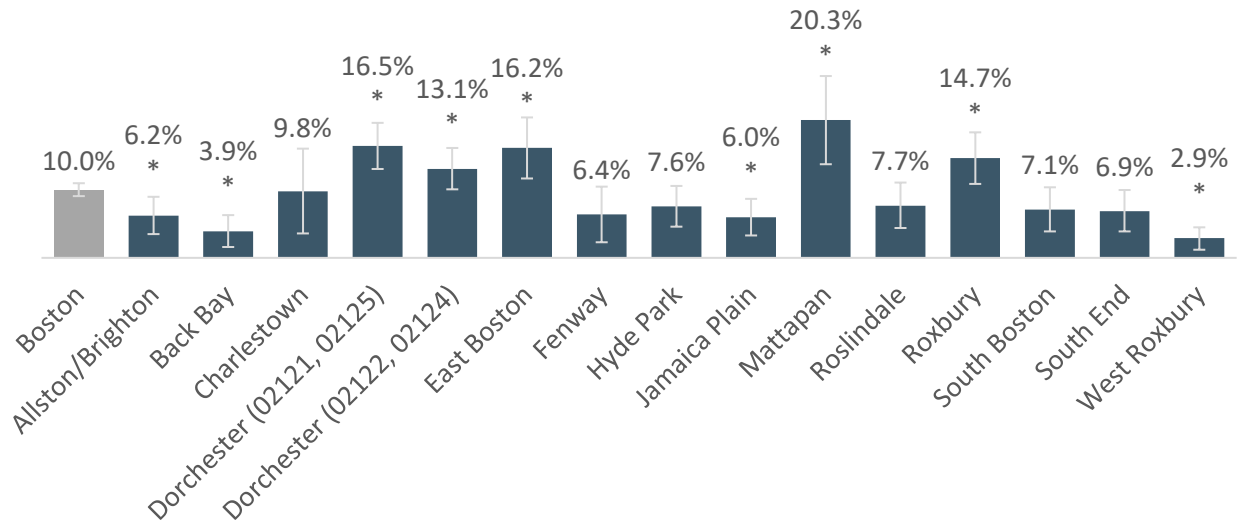
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting it was sometimes or often true that the food did not last and they did not have money to get more; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05); Error bars show 95% confidence interval

Figure 43. Percent Adults Reporting Food Purchased Did Not Last and Did Not Have Money to Get More, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



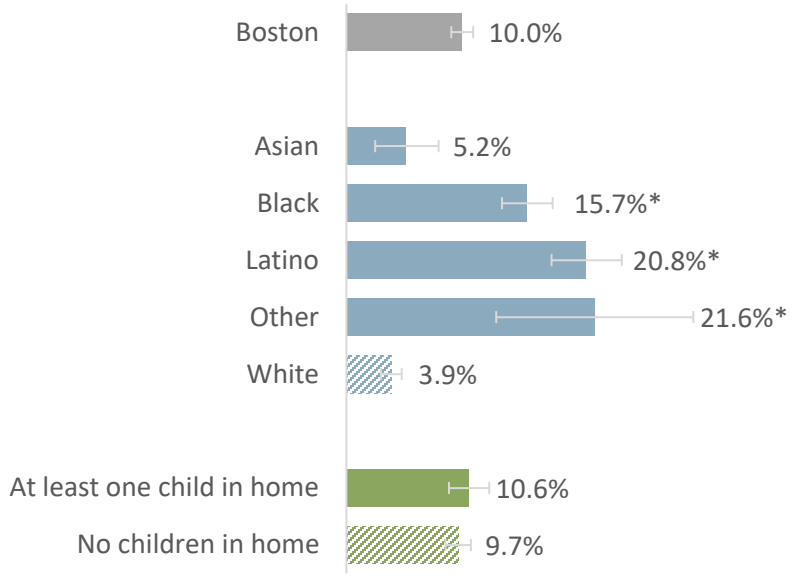
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting it was sometimes or often true that the food didn't last and they did not have money to get more; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 44. Percent Adults Reporting Feeling Hungry But Did Not Eat Because Could Not Afford Food, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



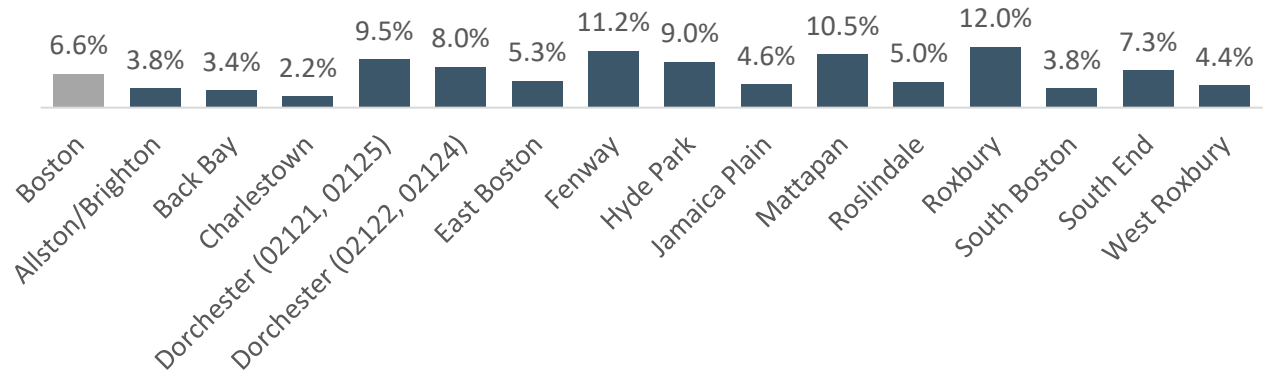
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting it was sometimes or often true in the past 12 months they remained hungry because they could not afford food; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 45. Percent Adults Reporting Feeling Hungry But Did Not Eat Because Could Not Afford Food, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



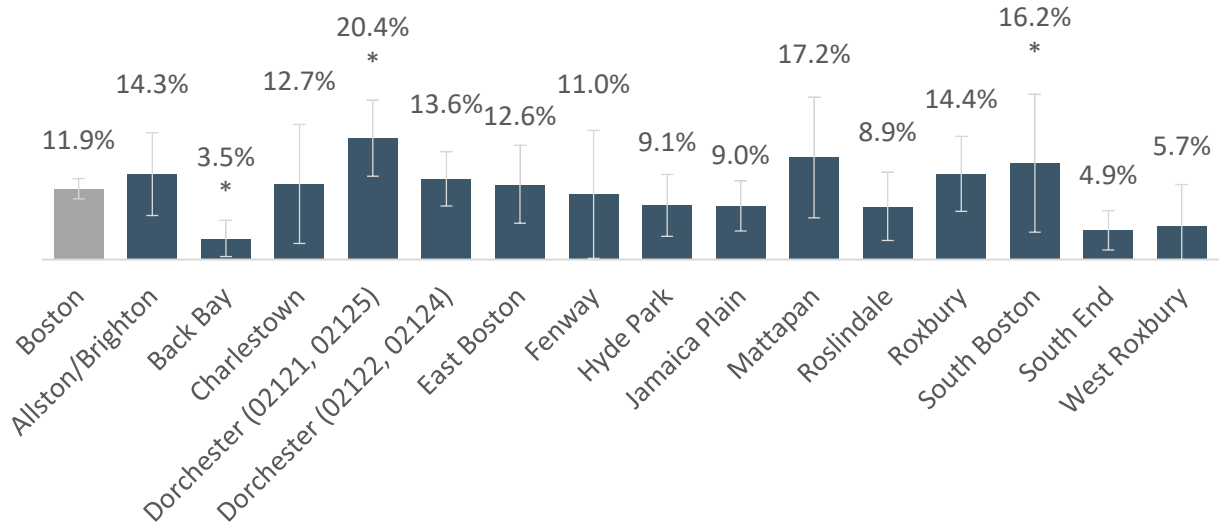
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting it was sometimes or often true in the past 12 months they remained hungry because they could not afford food; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 46. Percent Population 16 Years and Over Unemployed, by Boston and Neighborhood, 2015-2019



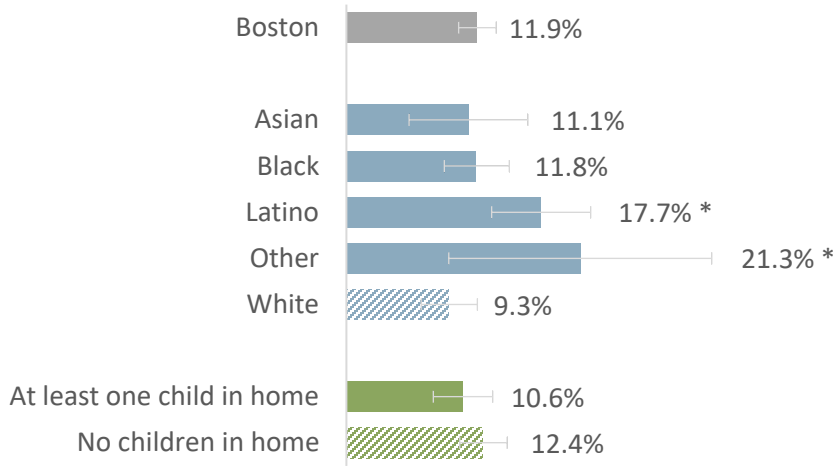
DATA SOURCE: U.S. Census, American Community Survey 5-Year Estimates, 2015-2019

Figure 47. Percent Adults Reporting Having Transportation Difficulties in Past Year, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



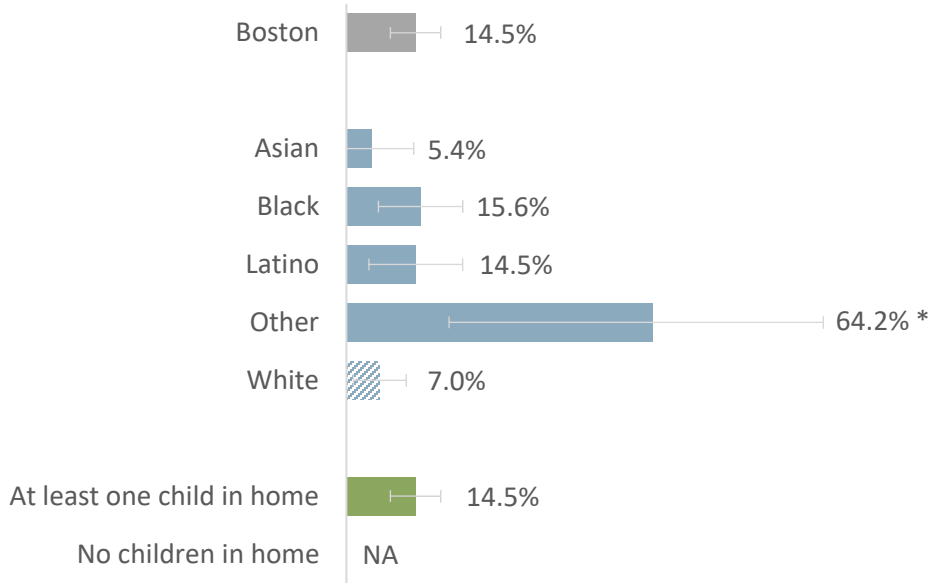
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting to that transportation difficulties have kept them from medical appointments, meetings, work, or from getting things needed for daily living in the past 12 months; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 48. Percent Adults Reporting Having Transportation Difficulties in Past Year, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting to that transportation difficulties have kept them from medical appointments, meetings, work, or from getting things needed for daily living in the past 12 months; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

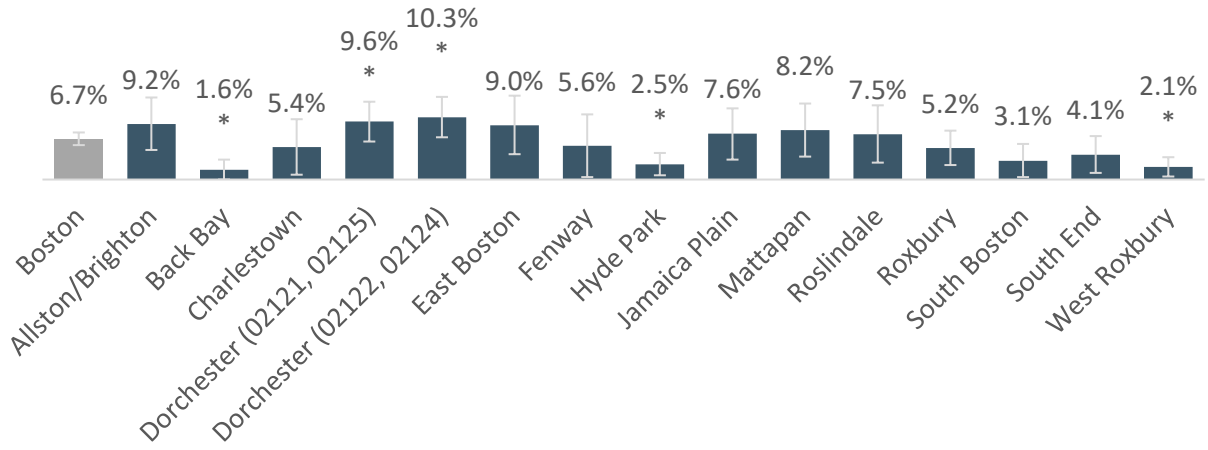
Figure 49. Percent Adults with Children Reporting Having Unmet Education Needs for Children or Teens in Household During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: NA denotes where data are not available because only respondents who indicated having at least one child present in the household were asked this question; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval

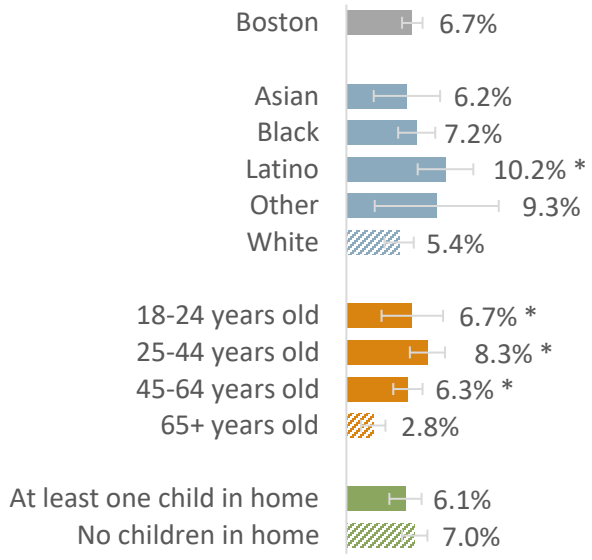
Housing

Figure 50. Percent Adults Reporting Moving in Past Three Years Because They Could No Longer Afford Their Home, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



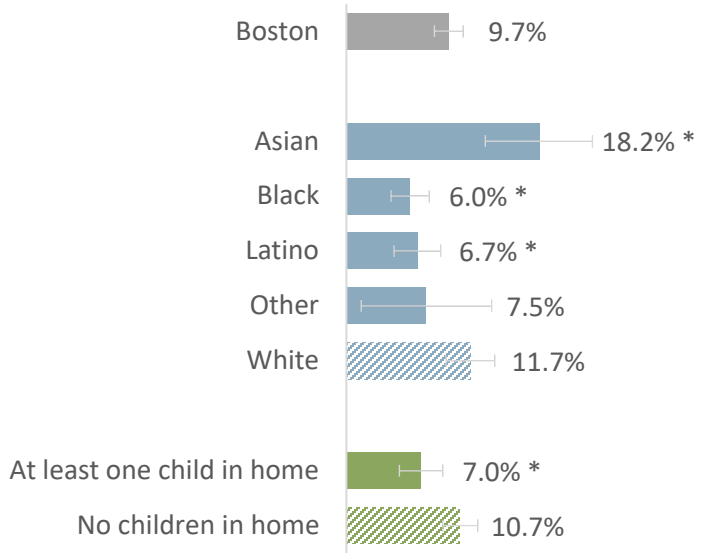
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 51. Percent Adults Reporting Moving in Past Three Years Because They Could No Longer Afford Their Home, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

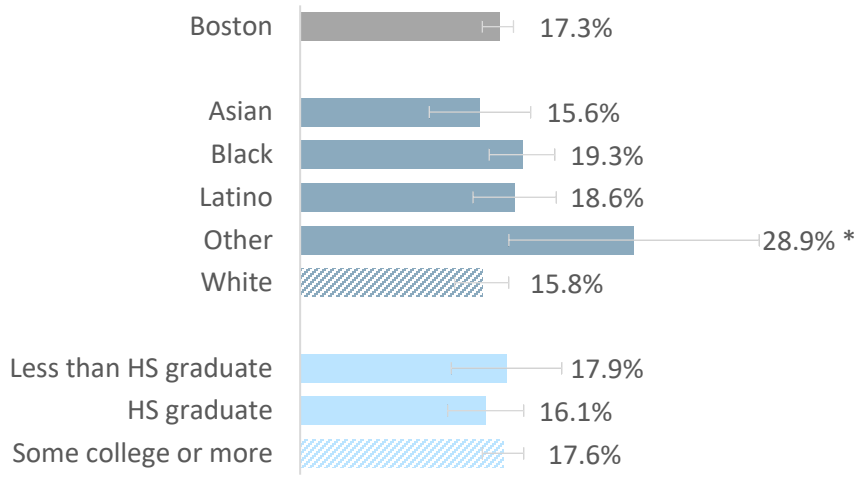
Figure 52. Percent Adults Reporting Living in Their Zip Code for Less Than One Year, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting they have lived in their zip code for less than one year in a row, excluding time as a student living on a college or university campus; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

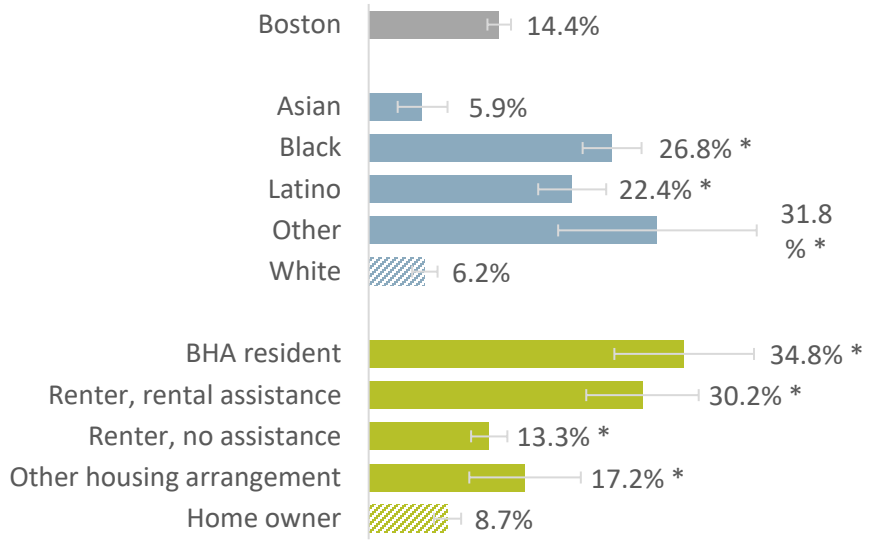
Behavioral Health

Figure 53. Percent Adults Reporting Being Threatened At Least Once a Year Due to Discrimination, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



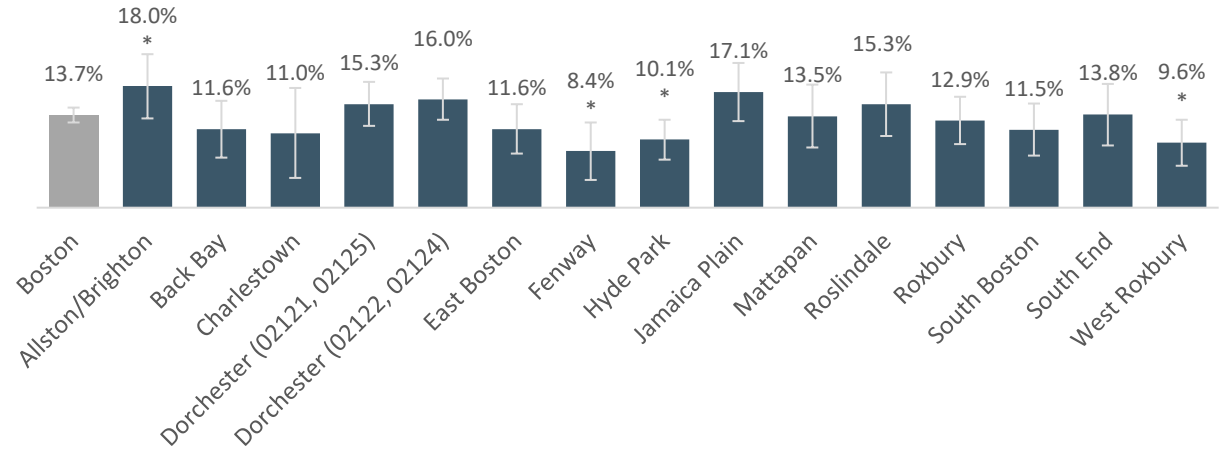
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting being threatened or harassed due to discrimination a few times a year, a few times a month, at least once a week, or almost every day; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 54. Percent Adults Reporting Their Neighborhood Unsafe, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



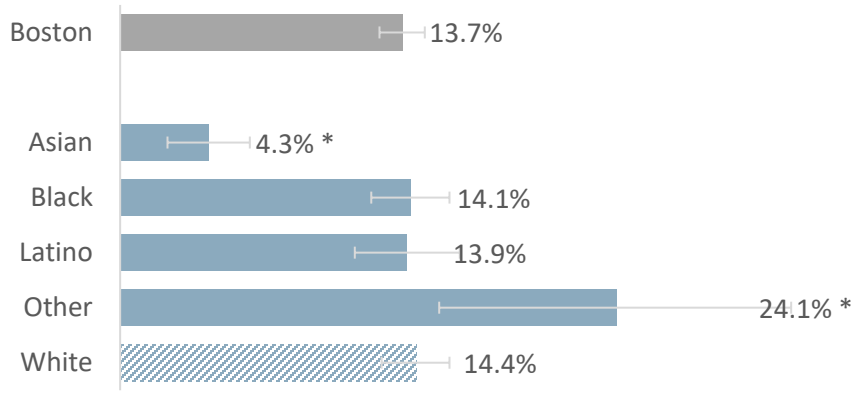
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting considering their neighborhood to be unsafe from crime; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 55. Percent Adults Reporting Experiencing Violence in Adult Lifetime, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



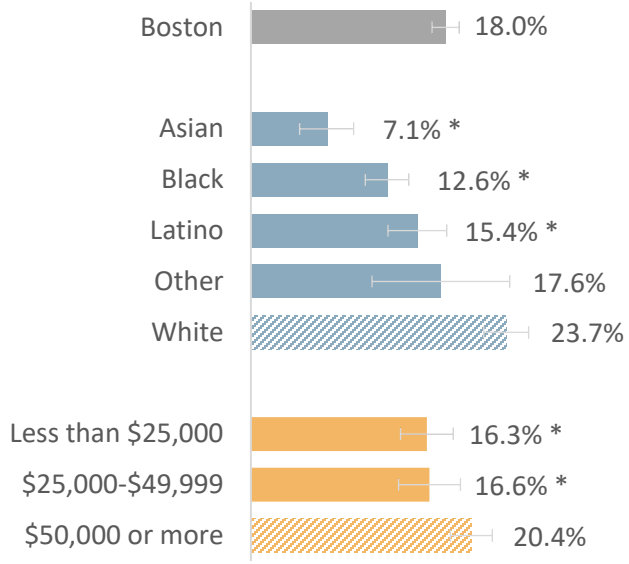
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults who reported to have experienced any physical or sexual violence since turning 18 years old; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 56. Percent Adults Reporting Experiencing Violence in Lifetime, by Boston and Race/Ethnicity, 2015, 2017, and 2019 Combined



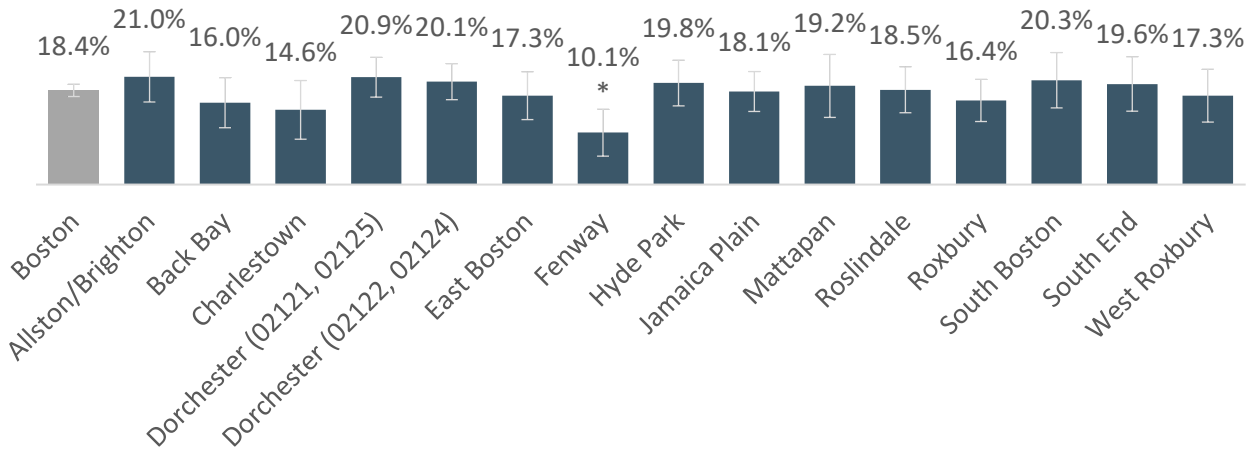
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults who reported to have experienced any physical or sexual violence since turning 18 years old; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 57. Percent Adults Reporting Having Lived with a Caregiver with Mental Illness as a Child (ACE), by Boston and Selected Indicators, 2015, 2017, 2019 Combined



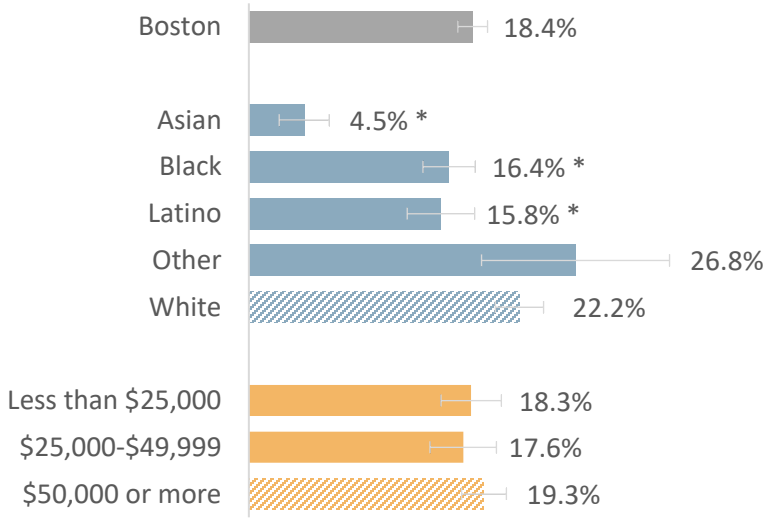
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting that they have ever lived with a parent or caregiver who was depressed, mentally ill, or suicidal; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 58. Percent Adults Reporting Having Lived with a Caregiver with Substance Misuse as a Child (ACE), by Boston and Neighborhood, 2015, 2017, and 2019 Combined



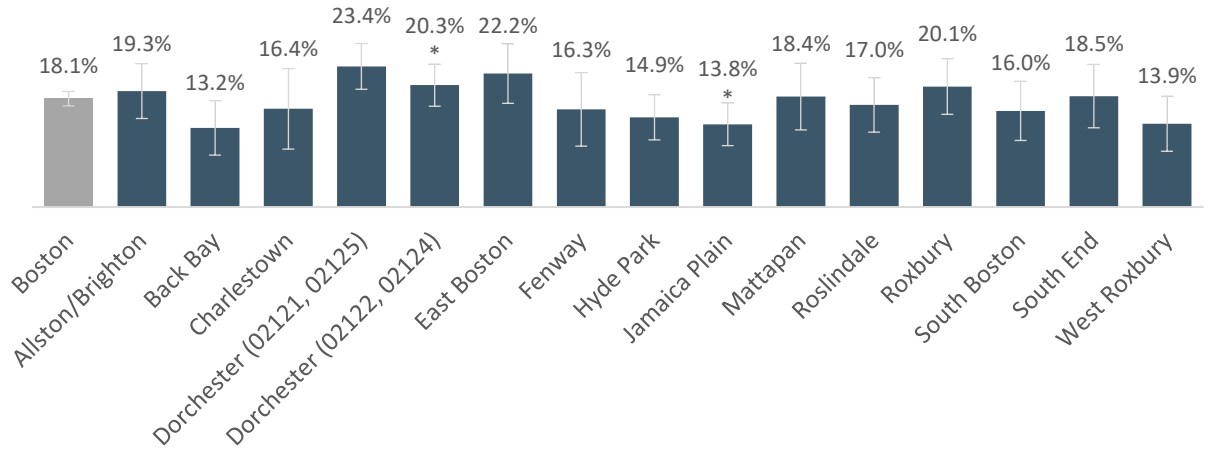
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting that they have ever lived with a parent or caregiver who was a problem drinker or alcoholic, or who used illegal street drugs or abused prescription medications; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 59. Percent Adults Reporting Having Lived with a Caregiver with Substance Misuse as a Child (ACE), by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



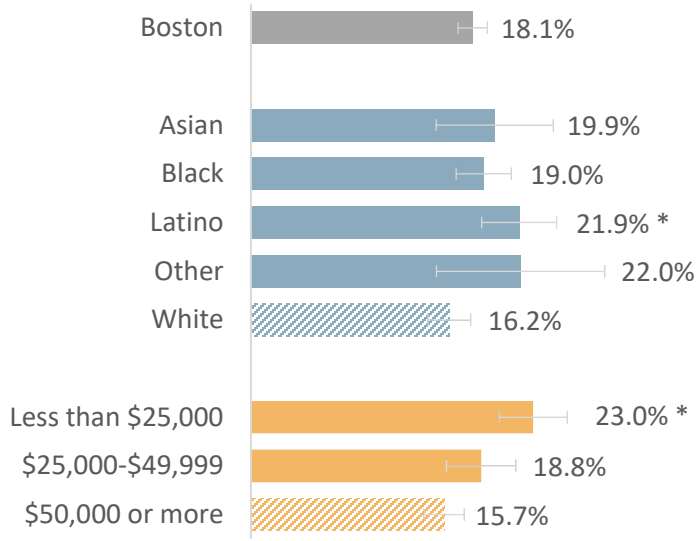
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting that they have ever lived with a parent or caregiver who was a problem drinker or alcoholic, or who used illegal street drugs or abused prescription medications; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 60. Percent Adults Reporting Having Lived with Adults who Physically Abused Each Other as a Child (ACE), by Boston and Neighborhood, 2015, 2017, and 2019 Combined



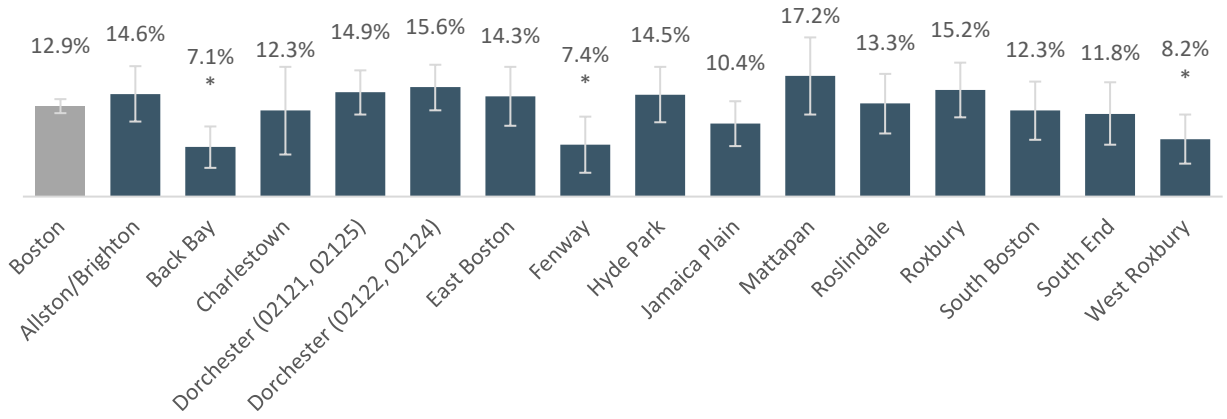
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting that their parents or the adults in their home ever slapped, hit, kicked, punched, or beat each other up; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 61. Percent Adults Reporting Having Lived with Adults who Physically Abused Each Other as a Child (ACE), by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



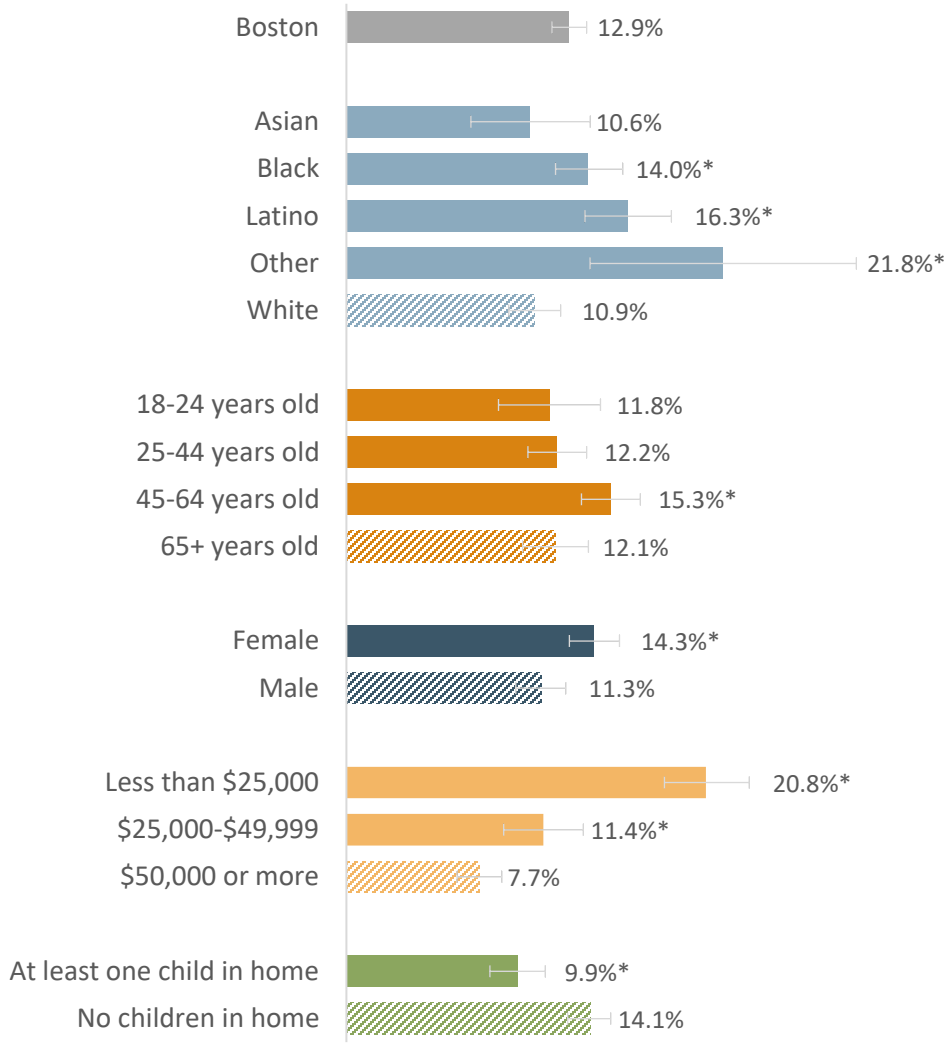
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting that their parents or the adults in their home ever slapped, hit, kicked, punched, or beat each other up; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 62. Percent Adults Reporting Persistent Sadness, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



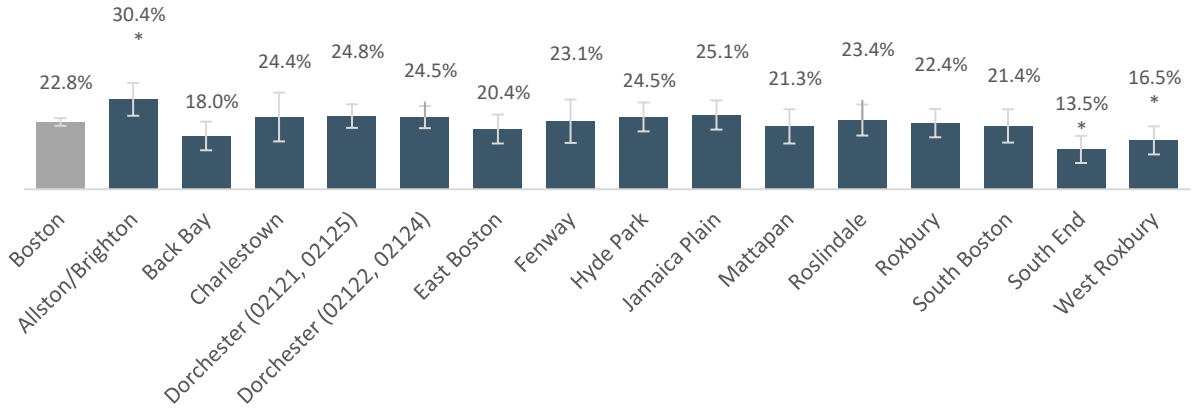
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Persistent sadness is defined as feeling sad, blue, or depressed for more than 15 days within the past 30 days; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 63. Percent Adults Reporting Persistent Sadness, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



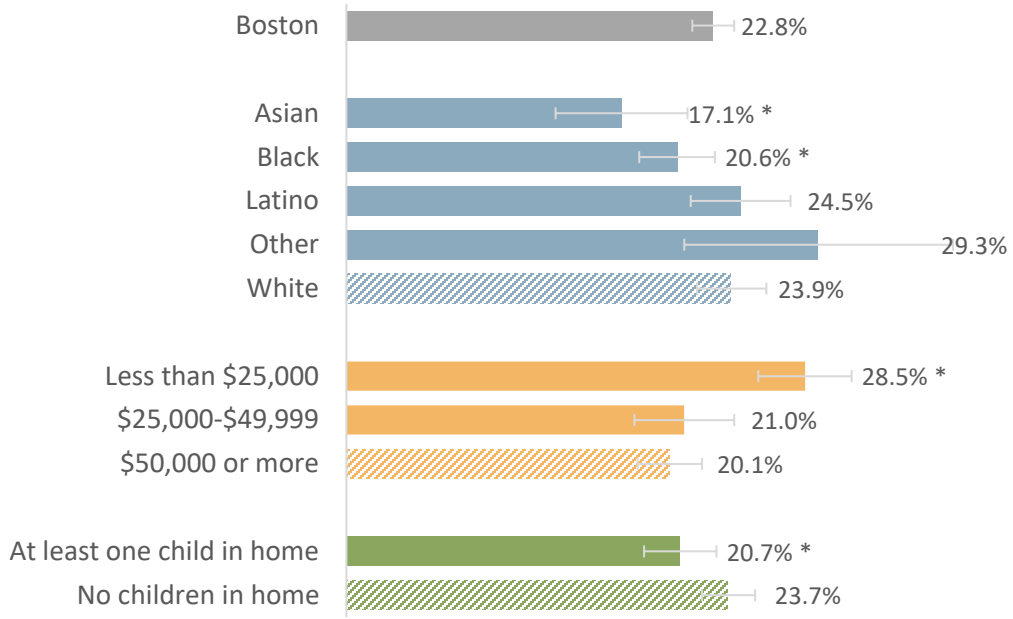
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Persistent sadness is defined as feeling sad, blue, or depressed for more than 15 days within the past 30 days; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 64. Percent Adults Reporting Persistent Anxiety, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



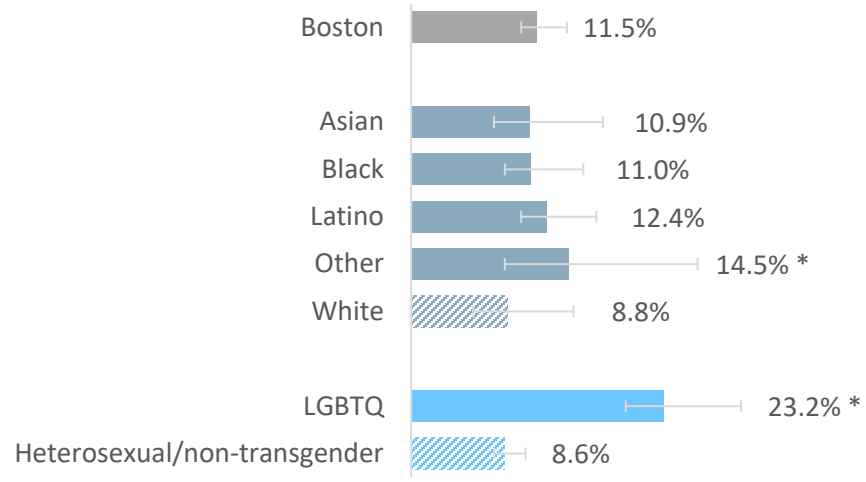
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Persistent anxiety is defined as feeling worried, tense, or anxious for more than 15 days within the past 30 days; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 65. Percent Adults Reporting Persistent Anxiety, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



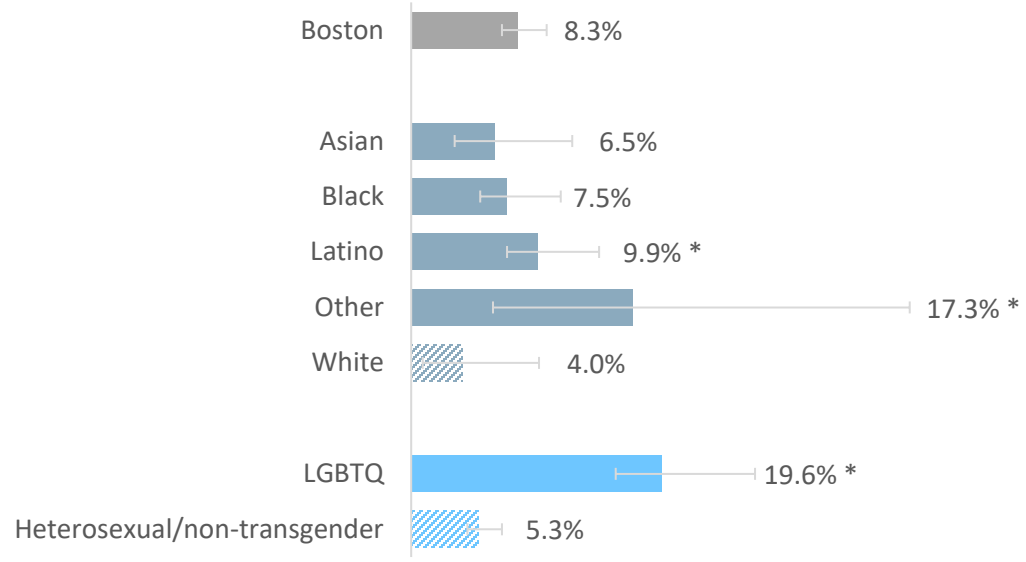
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Persistent anxiety is defined as feeling worried, tense, or anxious for more than 15 days within the past 30 days; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 66. Percent Boston Public High School Students Reporting Having Had a Suicidal Plan, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



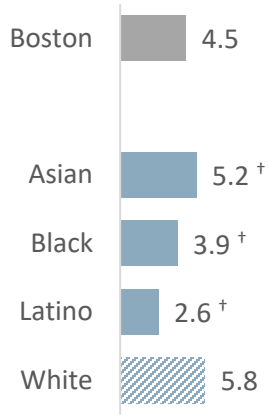
DATA SOURCE: Centers for Disease Control and Prevention and Boston Public Schools, Youth Risk Behavior Survey, 2015, 2017, and 2019 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTE: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 67. Percent Boston Public High School Students Reporting Attempting Suicide, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



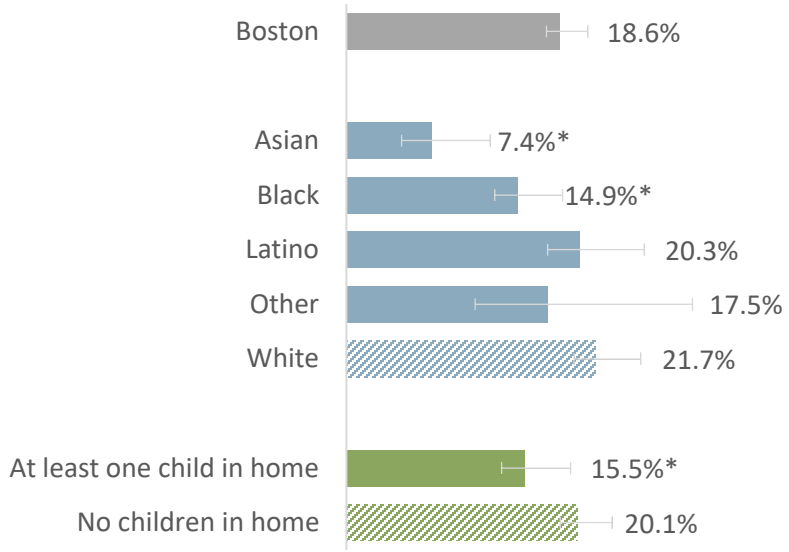
DATA SOURCE: Centers for Disease Control and Prevention and Boston Public Schools, Youth Risk Behavior Survey, 2015, 2017, and 2019 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTE: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 68. Suicide Rate, by Boston and Race/Ethnicity, Age-Adjusted Rate per 100,000 Residents, 2020-2021 Combined



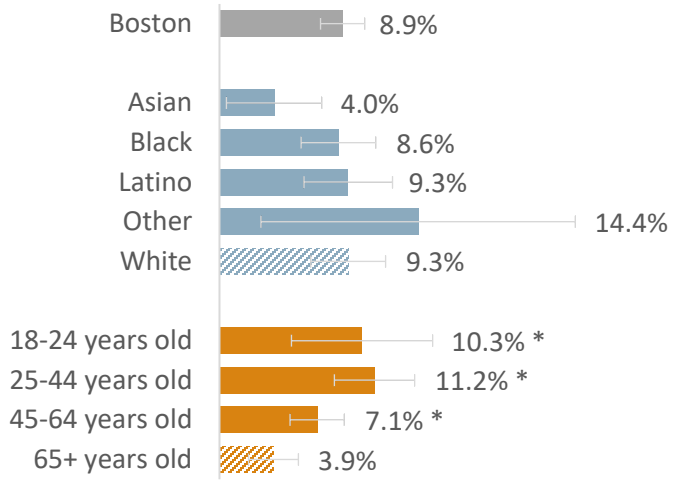
DATA SOURCE: Massachusetts Department of Public Health, Boston resident deaths, 2020-2021 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Massachusetts Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events; Dagger (†) denotes where rates are based on 20 or fewer deaths and may be unstable; No significant differences between estimates compared to the reference group were observed (p>0.05)

Figure 69. Percent Adults Reporting Receiving Treatment for Depression in the Past Year, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



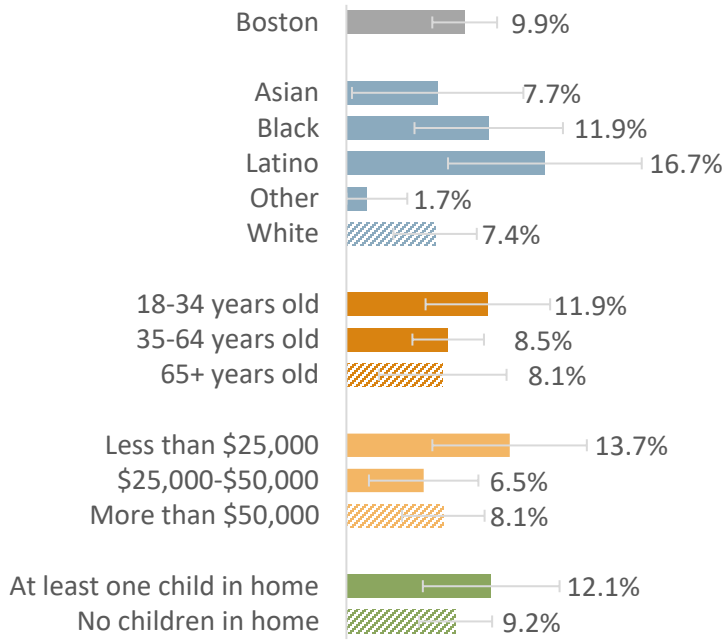
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 70. Percent Adults Reporting They Did Not Seek Mental Health Care Due to Cost in Past Year, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting there was a time in the past 12 months when they would have seen a therapist, psychologist, or psychiatrist but did not because of cost; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

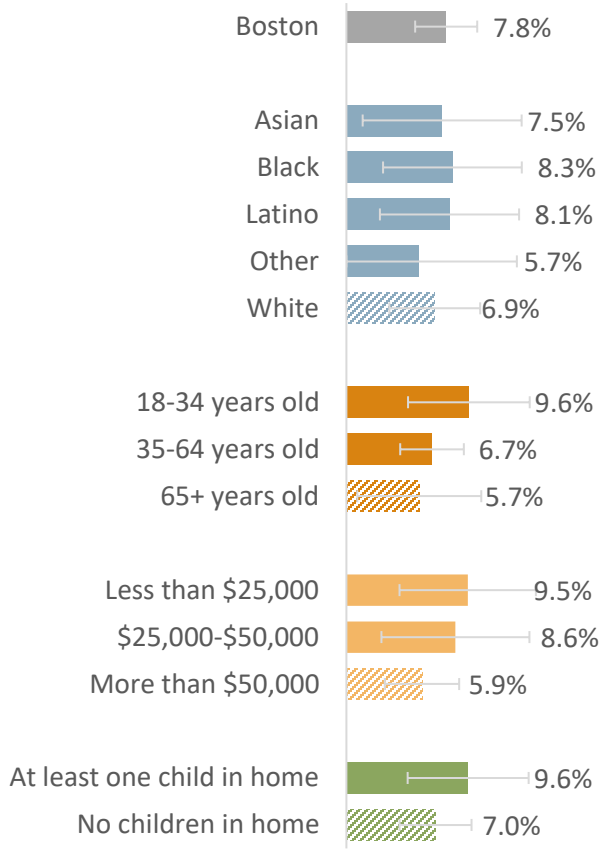
Figure 71. Percent Adults Reporting Delaying Mental Health Care Due to COVID-19 Concerns During the COVID-19 Pandemic, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office

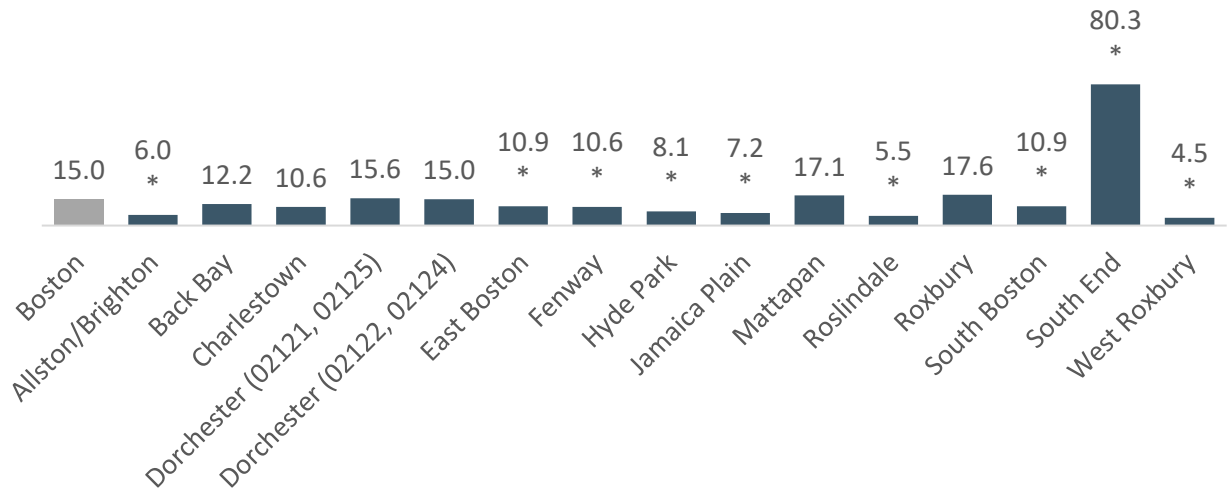
NOTES: Data show percentage of adults reporting to have avoided seeing a therapist or healthcare professional for mental health services due to concerns about COVID-19 since March 1, 2020; Percentage does not include adults reporting their appointments were canceled for them; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Figure 72. Percent Adults Reporting Still Delaying Mental Health Care due to COVID-19 Concerns, by Boston and Selected Indicators, December 2020-January 2021



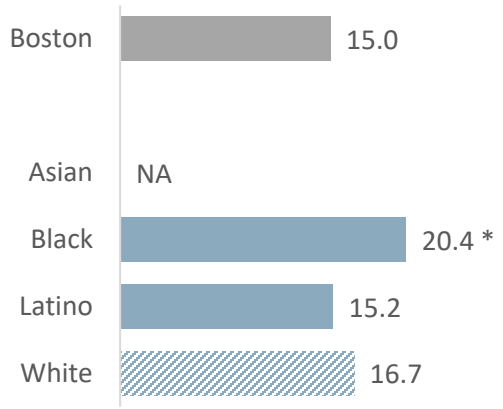
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Still delaying mental health care is defined as currently postponing or cancelling mental health services; Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Figure 73. Opioid Overdose-Related Hospital Patient Encounter Rate, by Boston and Neighborhood, Age-Adjusted Rate per 10,000 Residents, 2020



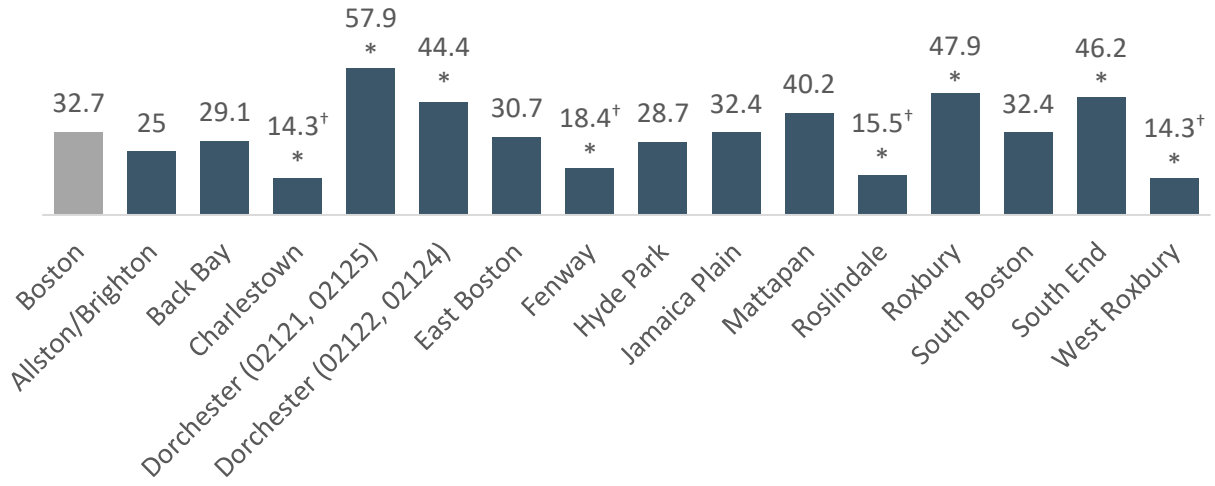
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$). Please note, opioid overdose hospital patient encounter levels are substantially impacted by patients identifying as homeless with residential zip codes reflecting corresponding homeless shelter zip codes. The people experiencing homelessness impact on neighborhood overdose rates varies considerably with specific neighborhoods (e.g., South End) experiencing substantially higher rates as a result.

Figure 74. Opioid Overdose-Related Hospital Patient Encounter Rate, by Boston and Race/Ethnicity, Age-Adjusted Rate per 10,000 Residents, 2020



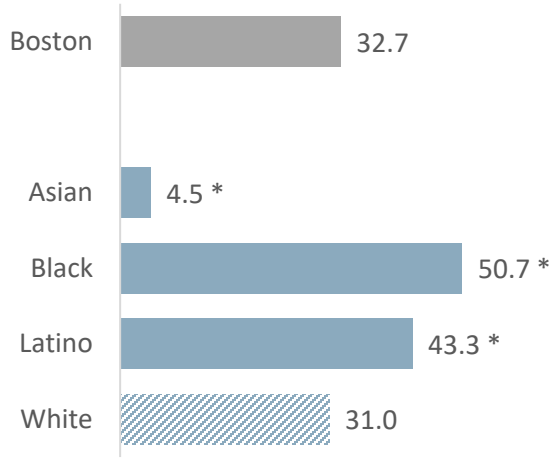
DATA SOURCE: Massachusetts Center for Health Information and Analysis, Acute Hospital Case Mix Databases, 2020
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$). NA denotes where data are not presented due to insufficient sample size

Figure 75. Unintentional Opioid Overdose Mortality Rate, by Boston and Neighborhood, Age-Adjusted Rate per 100,000 Residents, 2020-2021 Combined



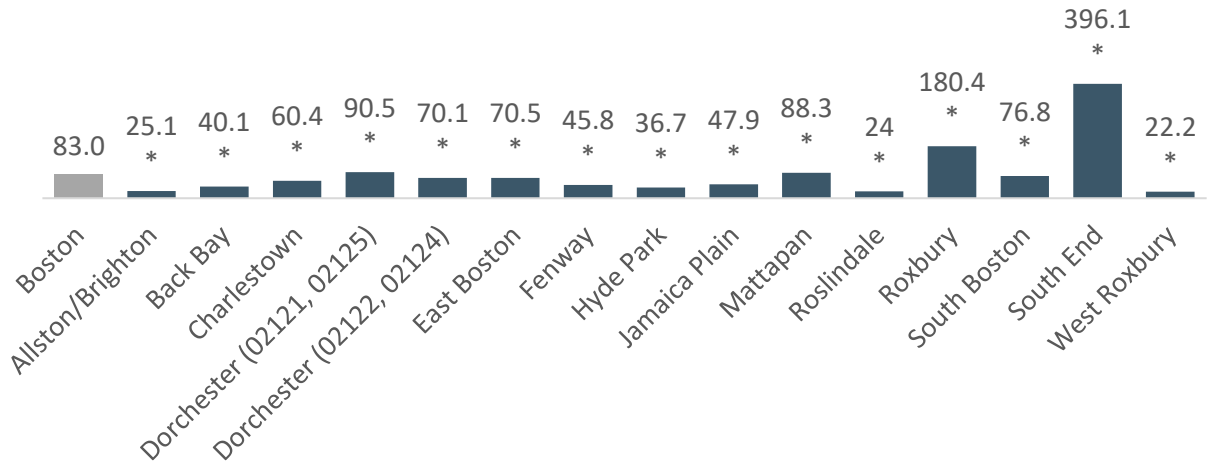
DATA SOURCE: Massachusetts Department of Public Health, Boston resident deaths, 2020-2021 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Massachusetts Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events; Dagger (†) denotes where rates are based on 20 or fewer deaths and may be unstable; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$). Please note, opioid overdose hospital patient encounter levels are substantially impacted by patients identifying as homeless with residential zip codes reflecting corresponding homeless shelter zip codes. The people experiencing homelessness impact on neighborhood overdose rates varies considerably with specific neighborhoods (e.g., South End) experiencing substantially higher rates as a result.

Figure 76. Unintentional Opioid Overdose Mortality Rate, by Boston and Race/Ethnicity, Age-Adjusted Rate per 100,000 Residents, 2020-2021 Combined



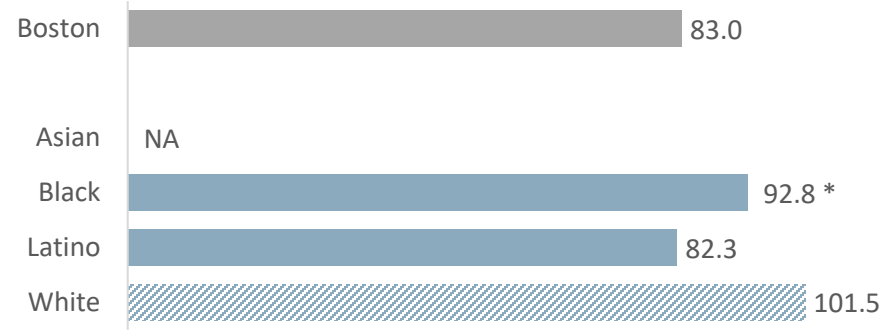
DATA SOURCE: Massachusetts Department of Public Health, Boston resident deaths, 2020-2021 combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Please be advised that 2020-2022 data are preliminary and subject to change. Raw preliminary data may be incomplete or inaccurate, have not been fully verified, and revisions are likely to occur following the production of these data. The Massachusetts Department of Public Health strongly cautions users regarding the accuracy of statistical analyses based on preliminary data and particularly with regard to small numbers of events; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05)

Figure 77. Unique Substance Use Treatment Admission Rate, by Boston and Neighborhood, Age-Adjusted Rate per 10,000 Residents, 2020-2021 Combined



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Substance Abuse Services, 2020-2021 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston (p < 0.05)

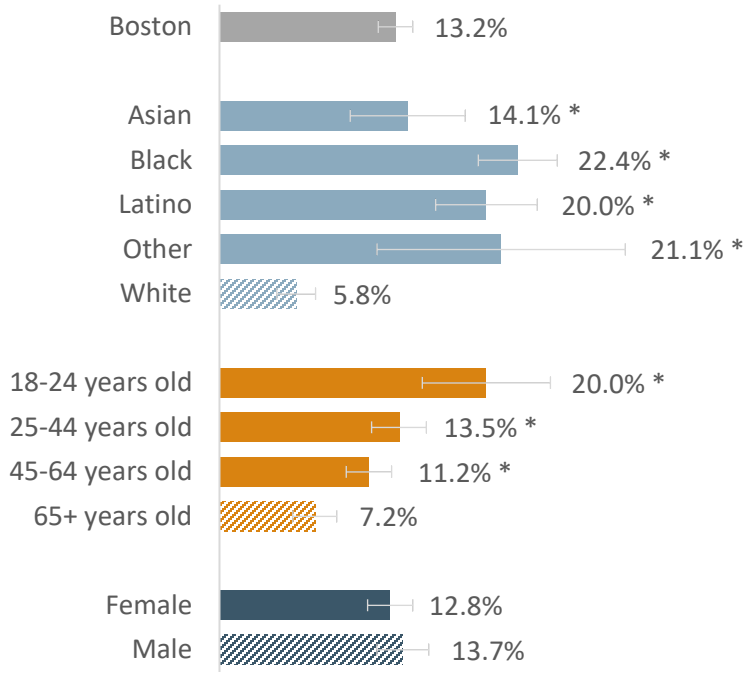
Figure 78. Unique Substance Use Treatment Admission Rate, by Boston and Race/Ethnicity, Age-Adjusted Rate per 10,000 Residents, 2020-2021 Combined



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Substance Abuse Services, 2020-2021 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); NA denotes where data are not presented due to insufficient sample size

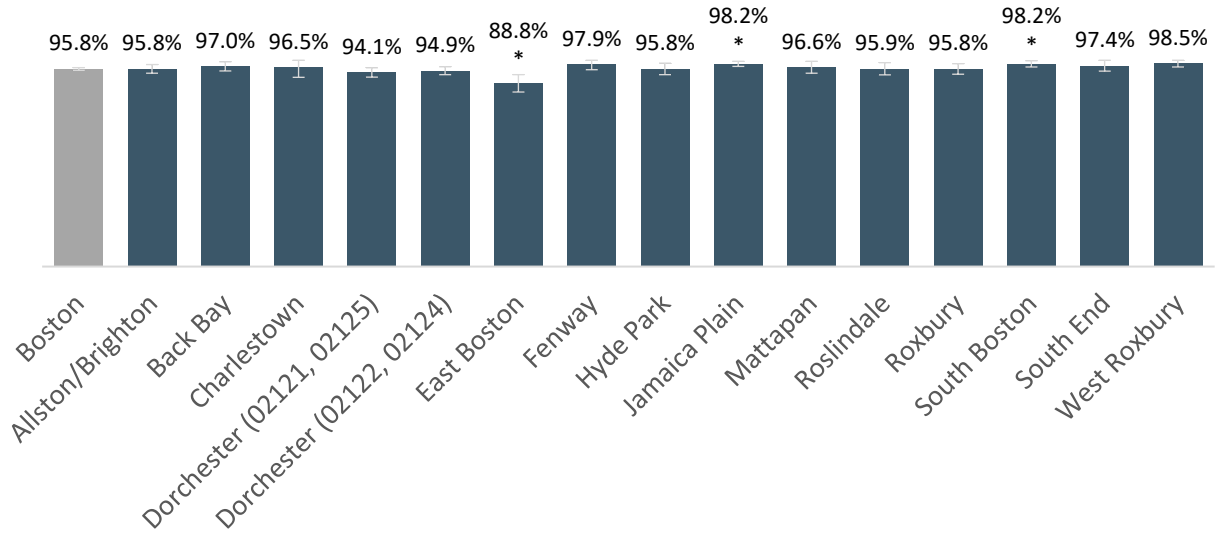
Access to Services

Figure 79. Percent Adults Reporting Receiving Poor Service At Least a Few Times a Month Due to Race/Ethnicity, by Boston and Selected Indicators, 2015, 2017, and 2019 Combined



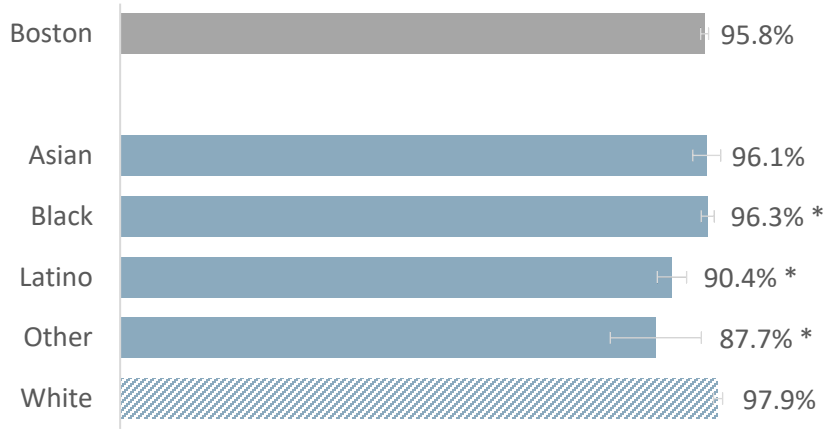
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentage of adults reporting receiving poorer service than other people at restaurants or stores in day-to-day life due to race/ethnicity a few times a month, at least once a week, or almost every day; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 80. Percent Adults Reporting Having Health Insurance, by Boston and Neighborhood, 2015, 2017, and 2019 Combined



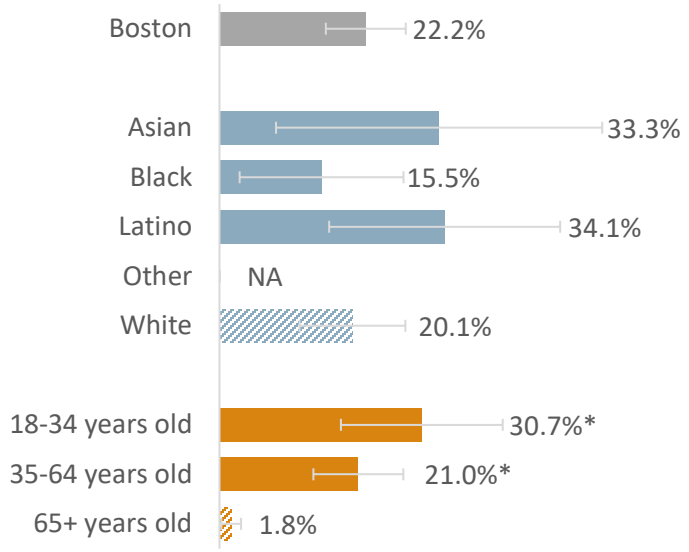
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentages of adults who reported that they have some kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare; Asterisk (*) denotes where neighborhood estimate was significantly different compared to the rest of Boston ($p < 0.05$); Error bars show 95% confidence interval

Figure 81. Percent Adults Reporting Having Health Insurance, by Boston and Race/Ethnicity, 2015, 2017, and 2019 Combined



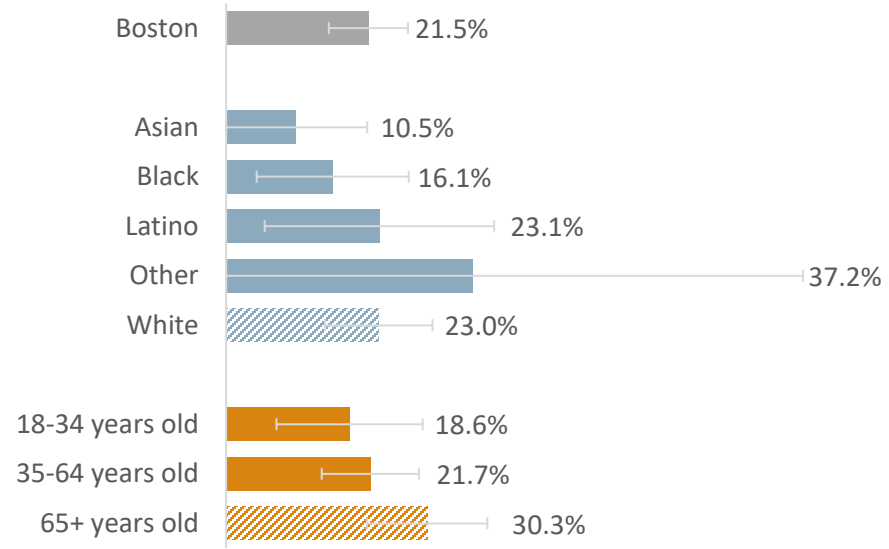
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, 2015, 2017, and 2019 Combined
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Data show percentages of adults who reported that they have some kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare; Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category ($p < 0.05$); Error bars show 95% confidence interval
For race/ethnicity, of the 201 respondents classified as Other, non-Hispanic, 23% identified as American Indian/Alaskan Native. The remainder are either multi-race or some other race.

Figure 82. Percent Adults Reporting Getting Time Off from Work as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



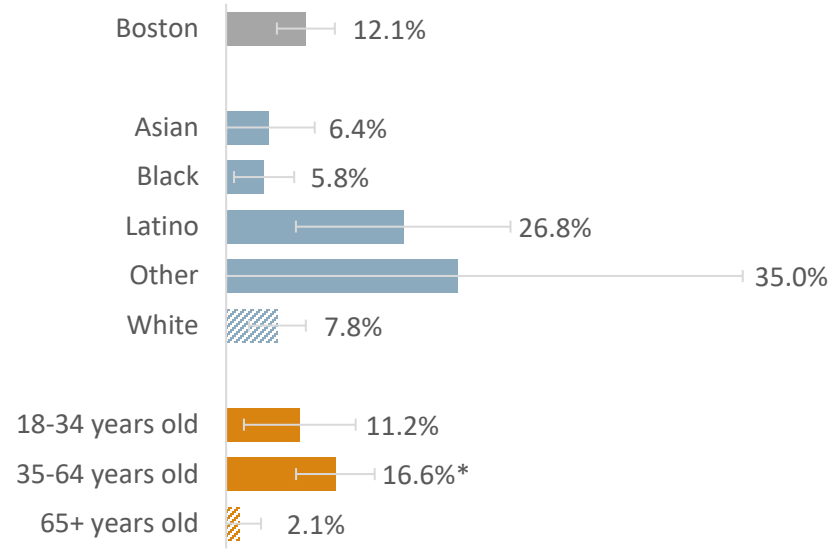
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval. NA denotes where data are not presented due to insufficient sample size.

Figure 83. Percent Adults Reporting Doctor Not Offering Test as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



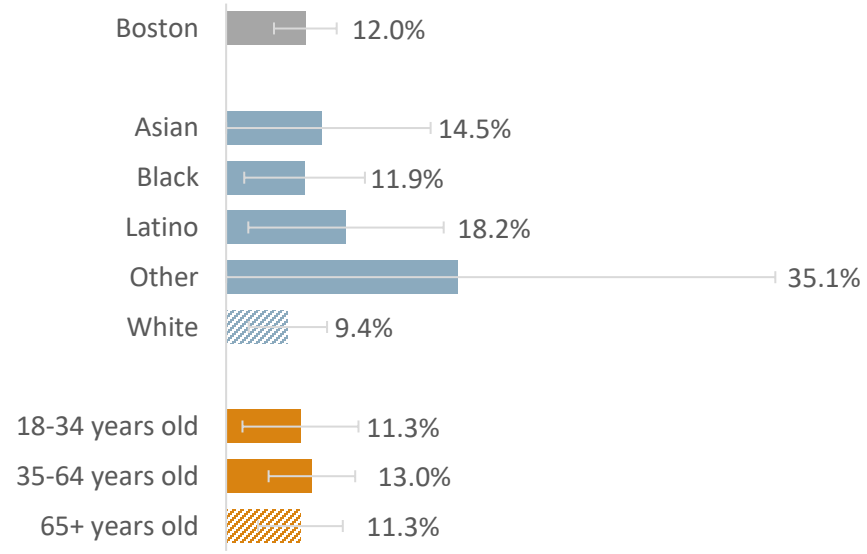
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Figure 84. Percent Adults Reporting Arranging Childcare as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



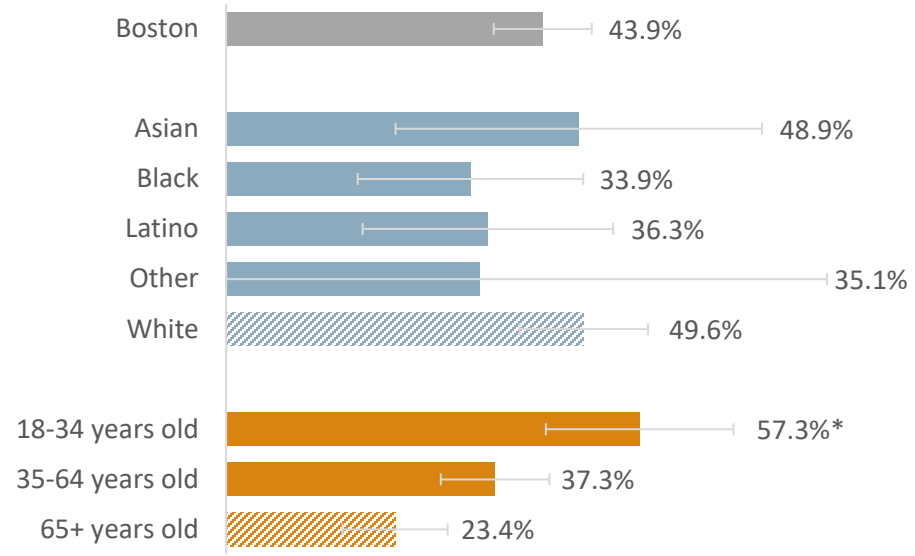
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 85. Percent Adults Reporting Not Having a Personal Doctor as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



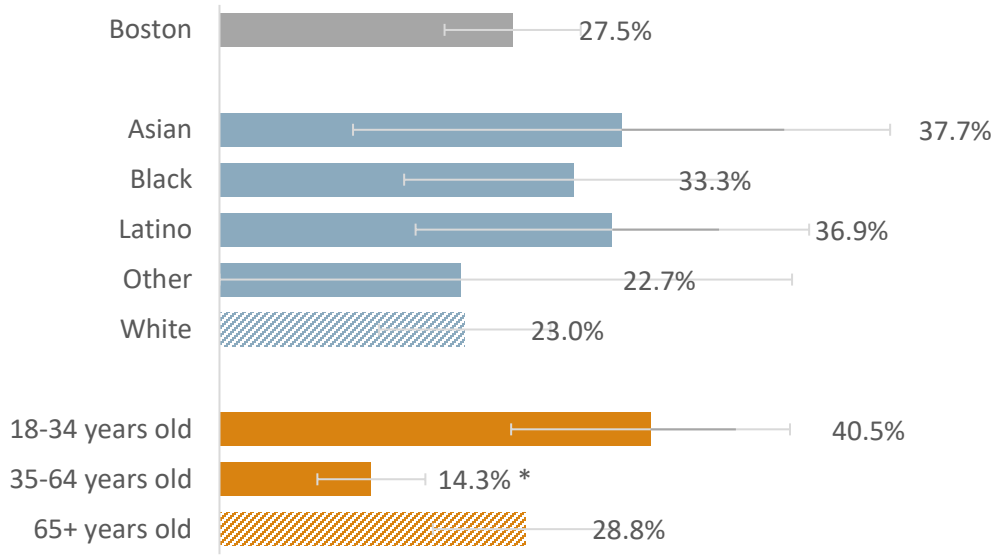
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Figure 86. Percent Adults Reporting Having a Referral or Symptoms which Qualify For Testing as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



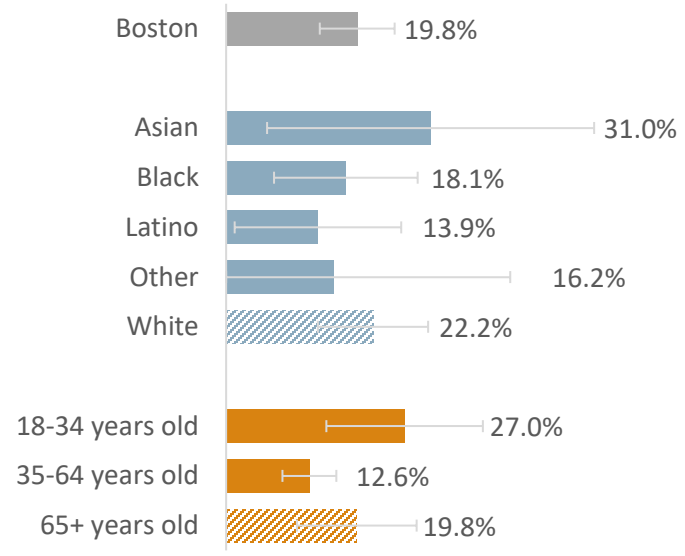
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 87. Percent Adults Reporting Getting to Test Location/Transportation as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



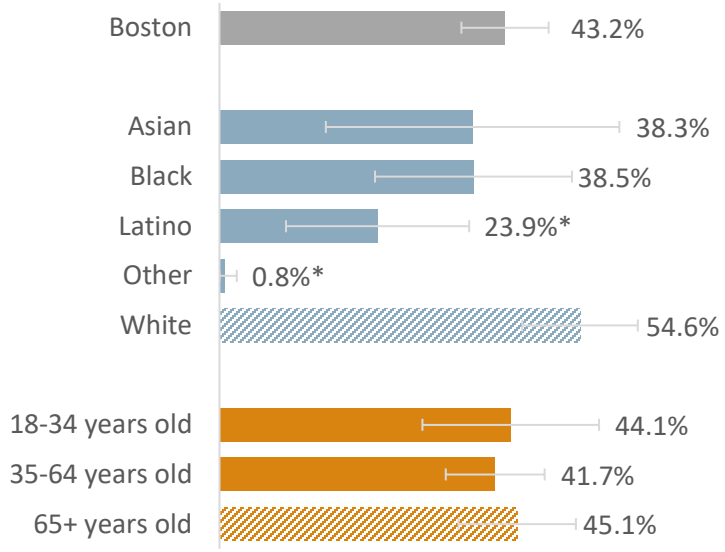
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 88. Percent Adults Reporting Cost of Test as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



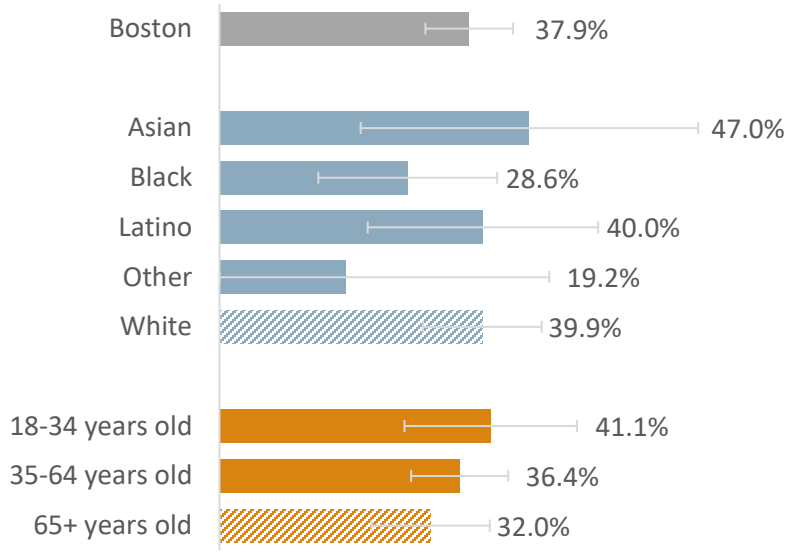
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

Figure 89. Percent Adults Reporting Finding a Clinic Offering a Test as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



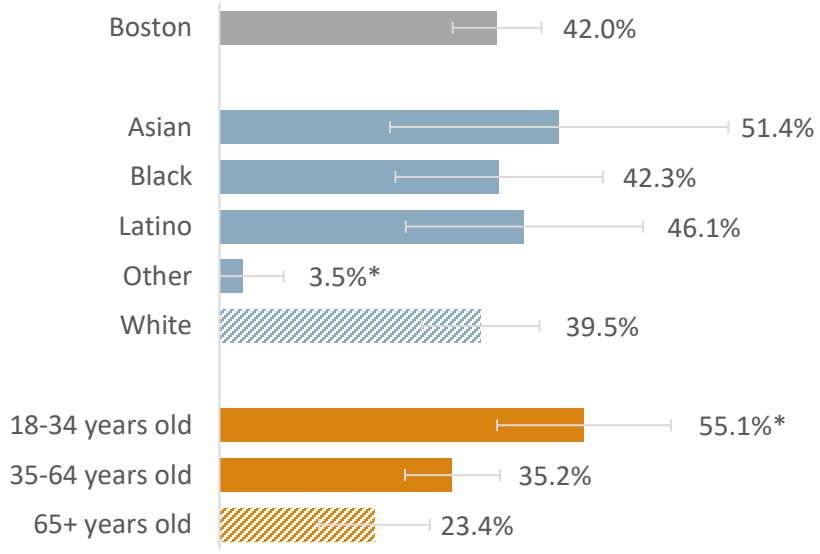
DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 90. Percent Adults Reporting Long Wait Time for Test Results as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

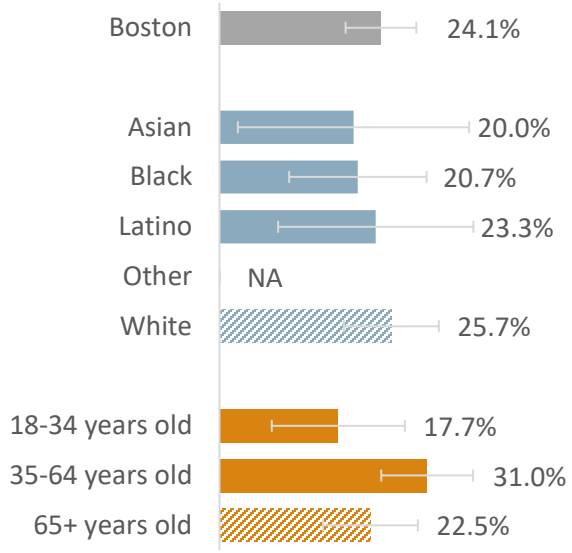
Figure 91. Percent Adults Reporting Time it Takes to Get Tested as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office

NOTES: Bars with pattern indicate reference group for its specific category; Asterisk (*) denotes where estimate was significantly different compared to reference group within specific category (p <0.05); Error bars show 95% confidence interval

Figure 92. Percent Adults Reporting Other Factors as Barrier to COVID-19 Testing, by Boston and Selected Indicators, December 2020-January 2021



DATA SOURCE: Boston Public Health Commission, Boston Behavioral Risk Factor Surveillance System, COVID-19 Health Equity Survey, December 2020 - January 2021
DATA ANALYSIS: Boston Public Health Commission, Research and Evaluation Office
NOTES: NA denotes where data are not presented due to insufficient sample size; Bars with pattern indicate reference group for its specific category; No significant differences compared to reference groups within specific categories were observed (p>0.05); Error bars show 95% confidence interval

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North Suffolk Public Health Collaborative Community Needs Assessment

- Qualitative Themes Report
  - Community Survey
- Survey results by municipality

North Suffolk Themes from Qualitative Data Collection

The following themes were highlighted across focus groups and key informant interviews with participants in Chelsea, Winthrop, and Revere. The breakdown of themes provides insight into strengths that participants felt contribute to the health of their community, challenges that create barriers to community health, and participant suggestions to help alleviate these barriers.

Strengths

- **Assistance from First Responders/Municipal Assistance.** Focus group participants in Winthrop discussed the dedication of first responders and municipal commitment to residents, citing examples where first responders were there to assist and provide care when necessary.

- **Community Resilience.** Focus group participants and key informants described the resilience among residents, particularly in Chelsea; despite trauma, tremendous need, and the COVID-19 pandemic, participants stated there is an "incredible energy of resilience." When asked about the strengths of the community in Chelsea, one key informant stated, "It keeps rising out of the ashes and continues to be reborn and rebuilt", highlighting resilience seen in Chelsea. Resilience among community residents despite adversity was also a strength that was emphasized during qualitative data collection for the North Suffolk Integrated Community Health Needs Assessment (iCHNA) in 2019.

- **Community Connectedness.** Participants from Revere and Chelsea discussed the sense of collaboration in these two communities, stating that community partners often come together to collaborate with each other to provide resources to residents. Winthrop participants described a visible sense of community among residents. In addition, Revere youth focus group participants talked about the benefits of having a shared language and culture in their community, as many people are immigrants and/or identify as Hispanic/Latinx; youth said this is helpful because being able to speak Spanish when interacting with adults to obtain access to resources makes them feel more comfortable.

- **Access to Transportation.** Winthrop youth and senior focus group participants mentioned that having access to public transportation to travel around the community and to Boston was a strength. Youth stated that it was helpful to have the T close by and to have access to a T pass, and seniors mentioned having the Partners bus was helpful for getting to appointments at Massachusetts General Hospital and East Boston Neighborhood Health Center in Winthrop. Chelsea focus group participants also described having access to the MBTA bus as a strength in the community. Focus group participants of the 2019 iCHNA also mentioned transportation was an asset in their communities.

- **Small Town/City.** Participants in Winthrop and Chelsea focus groups shared that being in a small community was a strength because of the opportunity to get to know local officials and staff, such as the superintendent of schools, and it was also helpful in terms of accessing services.

Challenges

- **Social Isolation Among Older Residents**. The prevalence of social isolation was discussed in this community health needs assessment and the 2019 iCHNA. Participants highlighted the rise of social isolation among seniors and residents who are confined at home. Participants shared that some residents may have needs that are not being met because of social isolation.

  Suggestions for Improvement:
  - Collective efficacy among neighbors-residents work together to improve the neighborhood, which would further strengthen community connectedness.
  - Improve communication-use different methods outside of the Internet/online, and ensure communication is available in different languages, especially for residents with limited English proficiency.
  - Emphasize importance of face-to-face communication-participants stated there is a lack of personal touch during in-person appointments, particularly due to having a shorter amount of time with providers and feeling rushed. Participants also

stated that virtual visits with providers are helpful, but there are limitations because some things cannot be addressed during these visits.

- Improving the ability to advocate for oneself at medical appointments-focus group participants in Winthrop stated this is a need in the community.

- **Sense of Belonging in the Community.** Participants described a reduced sense of belonging among immigrants because they are treated as "less than". One focus group participant stated that immigrants are afraid to access benefits they are entitled to because they believe "the government will find and deport them". Lastly, focus group participants noted that immigrants often worry about how they/their families will be treated and often need help advocating for themselves.

- **Quality and Availability of Employment Opportunities.** Multiple participants emphasized the importance of receiving fair pay and having access to a safe work environment. Participants highlighted that economic stability would help alleviate multiple health issues; one participant stated, "If [they have] access to good jobs that are well-paid, their mental health, food insecurity, and affordable health improve". While discussing employment, participants described the stress families in Chelsea experience because residents often work multiple jobs to pay rent that continues to increase and to make ends meet. Participants also noted that while the pandemic has made people rethink about the quality of their work environment, residents do not have much choice in which jobs they will take and often take any job opportunity available to pay their bills. In addition, participants mentioned there is a vulnerability among undocumented residents, especially regarding wage theft; one participant provided an example of residents not receiving pay for three months but continuing to show up to work every day. Regarding youth employment, youth focus group participants in Winthrop mentioned there are limited high paying jobs in their local area so it is necessary to travel outside of town to find a job, and it can be a long process for obtaining a work permit and other necessary paperwork. Additionally, Winthrop youth noted the importance of having a high-quality work environment, with many participants saying they enjoy working with CASA because it is a nice work environment. Lastly, Revere youth participants said that jobs

often have a lot of requirements that people may not always agree with, such as vaccine requirements, which may hinder access to job opportunities.

- **Impact of Lack of School Funding, Trauma, and Stress on Youth.** Several participants talked about issues pertinent to youth in their communities. Youth in Revere and Winthrop stated that there is not enough funding for schools, and as a result, there are no guidance counselors, not enough teachers, and large class sizes. In addition, Chelsea and Winthrop youth talked about being stressed because they do not have a break from managing schoolwork, jobs, and other demands, and Chelsea youth mentioned they do not have a place to just relax after school, such as a youth center. Additionally, participants highlighted the negative impact of growing up with trauma and how that contributes to people wanting to leave their community due to feeling uncomfortable. Lastly, youth focus group participants highlighted issues with bullying in school that were often unresolved and not adequately handled, which negatively impacts youth.

  Suggestions for Improvement:
  - Invest in youth through education and employment opportunities
    - Youth in Winthrop suggested providing effective education on bullying, in addition to having clear and consistent policies that address bullying in schools.
  - Mentorship opportunities
  - Provide mental health resources-participants stated that youth mental health needs in the community were currently not being addressed.
  - Uplift youth

- **Impact of Racism and Negative Perceptions of Particular Racial & Ethnic Groups on Policy and Socialization.** Participants highlighted the prevalence of structural racism as a barrier for many people of color and immigrants in the North Suffolk area, especially regarding access to healthcare. One participant mentioned that the health of Black and Brown communities is not prioritized, especially at the state level. In addition, participants noted that the policies currently in place negatively impact immigrants. Furthermore, youth participants talked extensively about racism and cultural appropriation. A participant stated they felt targeted at school, and participants noted that

Hispanic students specifically take certain tests that aim to demonstrate skill proficiency and measure "how well the government is doing their job"; one participant provided an example of a teacher automatically assuming the participant needed papers in Spanish because the participant took a test for people learning English, instead of providing an option to have papers in English. Chelsea youth noted differential treatment of people due to skin color and/or race/ethnicity, especially in school. Youth said they hear non-Black peers saying the n-word in school and that pretty much everyone says it without knowing the true context and history of the word; the use of the n-word by non-Black people seemed to upset youth focus group participants, as they felt it was not acceptable to say the n-word just because it is used in popular music. Youth in Chelsea also talked about seeing cultural appropriation in schools, as Black culture is perceived as a cool trend. Discrimination and lack of cultural sensitivity was a challenge mentioned in the 2019 iCHNA, where participants highlighted examples of discrimination due to language and cultural differences.

Suggestions for Improvement:

- Talk about racism in schools-Chelsea youth mentioned the lack of education their peers have regarding racism and the context behind the n-word.

- **Representation and Inclusion.** Several Chelsea participants emphasized the importance of seeing people who look like them rather than solely seeing people represented from the dominant racial/ethnic group in the community; for example**,** one youth stated, "I'm not trying to say that it's a bad thing that Hispanics are mostly represented, but I feel like that's what the main priority is only because that's all they see." Chelsea youth talked about seeing a lot of support geared towards Hispanic people and felt that non-Hispanic people, especially Black people, should have more opportunities to feel included and supported. Chelsea youth also mentioned that people in the community often make assumptions about what people like or want based on seeing majority Hispanic representation. While diversity is recognized as a strength in North Suffolk, qualitative data suggests that some residents do not feel adequately represented or seen in their communities. One participant stated, "We attempt to fight back and include voices, but with everything happening around them telling them they don't matter, too many of our residents don't want to speak up". In addition, participants stated they do not feel that

community voices and lived experiences are uplifted and mentioned disenfranchisement. Participants in Winthrop also stated that people in the community often do not have their voices heard due to the lack of local coalitions.

Suggestions for Improvement:

- Invest in the political power of community members
- Value contributions from community residents
- Expand opportunities for community voices to be heard
- Increase representation and inclusion of non-Hispanic residents
- Build initiatives at the local level, then bring them to state/federal levels

- **Toxins and Pollution in the Environment.** Participants, particularly in Chelsea and Winthrop, pointed out the impact of toxins and pollutions on air quality in their communities. Winthrop participants talked about the effects of the airport and community concerns about cancer. Participants in Chelsea, including youth, talked about an increase in vehicular traffic and cars, and highlighted the frequency of construction in the community as well, which has also negatively impacted air quality. Environmental concerns were flagged as a challenge in 2019 iCHNA, especially regarding the airport and air pollution.

  Suggestions for Improvement:

  - Implement state policy around environmental justice, air quality, and green space
  - Implement regulations on air pollution

- **Lack of Physical/Open Space.** Participants stated that the condition of parks in their communities impacted their health; litter and cleanliness of parks and outdoor areas were highlighted in a couple of focus groups and interviews. Revere and Chelsea youth mentioned there is a lot of drug/substance use, violence, and trash in parks; as a result, people do not feel safe in the park due to the negative connotation. One participant stated, "It just gave us and our parents the ideology like 'Oh don't go to that place. It's not a safe place. Only bad people go there".

Suggestion for Improvement:

- Increase green spaces and parks- overall, Chelsea participants expressed the need for increased availability of open spaces and clean air, as well as more parks.

- **Low Housing Stock and Poor Housing Conditions.** Multiple participants stated there is a need for safe and affordable housing in their communities. Participants shared there is a lack of stability regarding housing and a threat of displacement due to private housing options. In addition, one participant mentioned there is a shift from owner-occupied units to investor-owned properties, which has negatively impacted the quality of housing conditions. Rising costs of rent and utilities was also described as a concern, as well as issues with overcrowding, as multiple people are sharing one bedroom and bathroom. One participant described how difficult it is to buy a house in the neighborhood, as buildings are bought by large companies: "I can see all the big buildings around my house and know I can't afford them and it's not family friendly. I want to buy a house and it is very hard to buy a house and there is no program that we can apply for…We are fighting to be here". Lastly, participants noted that limited state and local policies, such gaps in rental assistance were unhelpful. Housing conditions and availability were also highlighted as a challenge during 2019 iCHNA data collection.

- **Vaping in School Bathrooms.** Revere and Winthrop youth discussed the increase of vaping, particularly in the school bathrooms. Youth in Revere noted that vaping is increasing among freshmen. The increase in vaping has negatively affected the ability to use school bathrooms, as youth are occupying the stalls to use vapes, and youth stated that vaping is unhealthy because of the smell and smoke in the lungs. Youth shared that some of the school bathrooms were closed because of vaping, and the bathrooms that remained open were in inconvenient locations. Revere youth mentioned that peers know where to get vapes because there is a trading system. In addition, youth felt that even if vapes are taken away from their peers, they will still find a way to use them. One participant stated that youth did not discuss vaping with their family members, which suggests that this may contribute to ongoing use. Revere youth stated there is a low perception of harm with vaping, as their peers see it as less dangerous than smoking cigarettes. Despite knowing the damages vaping may have on their bodies, youth shared

that their peers continue to use vapes, possibly to look cool. In addition, youth said they see influencers smoking while telling other people not to smoke, which is ineffective.

Suggestion for Improvement:

- Have someone outside of the bathroom to monitor vaping use
- Put in more smoke detectors

- **Impact of Limited Mental Health Supports.** Focus group participants and key informants highlighted an overwhelming need for mental health services, as many people are grappling with unresolved mental health issues due to loss, trauma, and stress. In addition, participants mentioned that low reimbursement rates impact services and lead to low salaries, resulting in people leaving the field when there are a limited number of providers as it is. Furthermore, participants talked about the system being complex and complicated to navigate, which affects access to services. Concerns around mental health issues and limited services were also highlighted in the 2019 iCHNA.

  Suggestions for Improvement:

  - Additional mental health services/practitioners
  - Prioritize behavioral health needs, and potentially utilize people from non-clinical fields to assist, such as community health workers
  - Expand access to mental health services through places/programs residents already utilize, such as faith-based programs
  - Build skills among residents to cope with stressors

- **Impact of Politics on Residents.** Participants highlighted healthcare inequities and issues with communication due to a lack of effective policies at the local level. In addition, participants stated that public health has been politicized. Focus group participants also noted that the response to the COVID-19 pandemic has been politicized, particularly regarding masks and vaccines. Participants shared frustration with a lack of effective policies for pertinent issues, especially those that disproportionately affect certain groups. For example, a Chelsea participant mentioned there is no willingness to put money into resources for immigrants and policies affecting immigrants; participants shared this sentiment regarding environmental justice policies as well. In addition, participants stated that focusing on a regional approach rather than a local approach has

hindered residents because resources are limited. Lastly, Chelsea participants noted that people are interested and invested in making change, but there is no push to implement policies at the local level.

- **Quality and Frequency of Transportation.** Although access to transportation is a strength**,** public transportation is also seen as dated and overcrowded. In addition, participants described the challenge of transportation schedules. Seniors in Winthrop said that although the Partners bus is helpful for getting to appointments, it runs on a limited schedule. In addition, participants in Chelsea talked about the infrequent schedule of the buses, as one participant shared that their mom had to wait three hours for a bus and missed a job interview as a result. Transportation was also mentioned as both a strength and challenge in the 2019 iCHNA.

***Suggestions for Improvement*:**

- Partners bus could run on a more frequent schedule
- Offer free/low-cost public transportation for students and residents with limited resources

North Suffolk Public Health Collaborative
Community Survey

The North Suffolk Public Health Collaborative (NSPHC) is conducting a Community Health Assessment to explore the community health strengths and challenges that matter most to people in our communities – Chelsea, Revere, and Winthrop. The purpose of this survey is to hear directly from community members like you. The results of this survey will be analyzed and shared back with the community, and will help NSPHC, our partner organizations, and community members to take action to positively change the factors that influence people's health.

Please read this important information before you begin the survey.

- This survey will take approximately 15 minutes to complete.
- If you do not feel comfortable answering a question, you may skip it.
- Taking this survey will not affect any services that you receive.
- This survey is being shared widely, including by other health systems such as Beth Israel Lahey Health, Cambridge Health Alliance, and Massachusetts General Hospital. Please complete it only once.
- This survey is anonymous. Your responses to this survey will be kept private. NSPHC staff and collaborators who analyze the survey data will have restricted access to the responses. Findings from this survey that are shared back with the community will be combined across all respondents. It will not be possible to identify you or your responses.
- You will have the option at the end of the survey to enter a drawing for a $100 grocery gift card, in appreciation of your participation. The contact information you provide to be entered into the drawing will not be attached to your survey responses in any way.
- If you have any questions about this survey, please contact Kelly Washburn at kwashburn@mgh.harvard.edu.

Do you understand the above information and agree to participate in this survey?

- Yes
- No

Thank you for being a part of this assessment process. Please turn the page to begin.

Your Community

1. We are interested in your experiences in the community where you spend the most time. This may be the place where you live, work, play, or learn. In which community do you spend the most time?
   - Chelsea
   - Revere
   - Winthrop

2. How many years have you lived in this community?
   - Less than 1 year
   - 1-5 years
   - 6-10 years
   - Over 10 years but not all my life
   - I have lived here all my life
   - I have never lived here, but I work here

3. How many years have you worked in this community?
   - Less than 1 year
   - 1-5 years
   - 6-10 years
   - Over 10 years
   - I have never worked here, but I live here

4. If you neither live nor work in this community, please describe how you are connected to it.

   _____

   _____

5. Please check the response that best describes how much you agree or disagree with each statement about your community.

	☐ Strongly Disagree	☐ Disagree	☐ Agree	☐ Strongly Agree	☐ Don't Know
I feel like I belong in my community.					
Overall, I am satisfied with the quality of life in my community.					
My community is a good place to raise children.					
My community is a good place to grow old.					
My community has good access to resources.					

6. What are the most important things you would like to improve about your community? Please select up to 5 items from the list below.

- Better access to health care
- Better access to healthy food
- Better access to public transportation
- Better access to good jobs
- Better schools
- Better access to internet
- Better preparedness for extreme weather (like heat waves and floods)
- Cleaner environment
- More affordable housing
- More affordable childcare
- More arts and cultural events
- More effective city services (like water, trash, fire and police services)
- Better roads and transit infrastructure
- Better sidewalks and trails
- Lower crime and violence
- Better parks and recreation opportunities
- More respect and inclusion for diverse members of the community
- Stronger community leadership
- Stronger sense of community
- Other (specify_____

_____

Natural and Built Environment

7. The natural and built environment impacts the health and wellbeing of people and communities. For each statement below, choose the response that best describes how true you think it is.

	Not at all true	Sometimes True	True	Don't know
My community feels inviting and safe.	•	•	•	•
People like me have access to safe, clean parks and open spaces.	•	•	•	•
People like me have access to reliable transportation.	•	•	•	•
People like me have housing that is safe and good quality.	•	•	•	•
The air in my community is healthy to breathe.	•	•	•	•
The water in my community is safe to drink.	•	•	•	•
During extreme heat, people like me have access to options for staying cool.	•	•	•	•
My community is prepared to protect ourselves during climate disasters, such as flash flooding, hurricanes, or blizzards.	•	•	•	•

Economic and Education Environment

8. The economic and educational environment impacts the health and wellbeing of people and communities. For each statement below, choose the response that best describes how true you think it is.

	Not at all true	Sometimes True	True	Don't know
People like me have access to good local jobs with living wages and benefits.	•	•	•	•
People like me have access to local investment opportunities, such as owning homes or businesses.	•	•	•	•
Housing in my community is affordable for people like me.	•	•	•	•
People like me have access to affordable child care services.	•	•	•	•
People like me have access to good education for their children.	•	•	•	•

Health and Access to Care

9. The healthcare environment impacts the health and wellbeing of people and communities. For each statement below, choose the response that best describes how true you think it is.

	Not at all true	Sometimes True	True	Don't know
Health care in my community meets the physical health needs of people like me.	•	•	•	•
Health care in my community meets the mental health needs of people like me.	•	•	•	•

10. In the last 12 months, did you ever need any of the following types of health care? Please check the response that best describes your experience.

	I needed this type of care and was able to access it.	I needed this type of care but could **not** access it.	I did not need this type of care.
Dental (mouth) care	•	•	•
Emergency care for mental health crisis, including suicidal thoughts	•	•	•
Medication for a chronic illness	•	•	•
Mental health care	•	•	•
Reproductive health care	•	•	•
Treatment for a substance use disorder	•	•	•
Vision care	•	•	•

11. For any types of care that you needed but were not able to access, select the reason(s) why you were unable to access care. You may select more than one.

	Concern about COVID exposure	Unable to afford the costs	Unable to get transpor-tation	Hours did not fit my schedule	Fear or distrust of the health care system	No providers speak my language	Another reason not listed here
Dental (mouth) care	•	•	•	•	•	•	•
Emergency care for mental health crisis	•	•	•	•	•	•	•
Medication for a chronic illness	•	•	•	•	•	•	•
Mental health care	•	•	•	•	•	•	•
Reproductive health care	•	•	•	•	•	•	•
Treatment for a substance use disorder	•	•	•	•	•	•	•
Vision care	•	•	•	•	•	•	•

If you answered “For another reason not listed here” for any of the above types of care, please describe why you were unable to access care.

_____

_____

Social and Cultural Environment

12. For each of the statements below, please check the response that best describes how much you agree or disagree with each statement.

There are people and/or organizations in my community that support me during times of stress and need.	▢ Strongly Disagree	▢ Disagree	▢ Agree	▢ Strongly Agree	▢ Don’t Know
I believe that all residents, including myself, can make the community a better place to live.	▢ Strongly Disagree	▢ Disagree	▢ Agree	▢ Strongly Agree	▢ Don’t Know
During COVID-19, information I need to stay healthy and safe has been readily available in my community.	▢ Strongly Disagree	▢ Disagree	▢ Agree	▢ Strongly Agree	▢ Don’t Know
During COVID-19, resources I need to stay healthy and safe have been readily available in my community.	▢ Strongly Disagree	▢ Disagree	▢ Agree	▢ Strongly Agree	▢ Don’t Know

13. Discrimination negatively impacts the health and wellbeing of people and communities. We are interested in the ways you are treated in your community. For each of the statements below, please check the response that best describes how often each experience happens to you.

	Never	Less than once a year	A few times a year	A few times a month	At least once a week	Almost every day
You are not hired for jobs for unfair reasons, are unfairly fired, or are denied a raise.	●	●	●	●	●	●
You are unfairly stopped, searched, questioned, threatened, or abused by the police.	●	●	●	●	●	●
You receive worse service than other people at stores, restaurants, or service providers.	●	●	●	●	●	●
Landlords or realtors refuse to rent or sell you an apartment or house.	●	●	●	●	●	●
Healthcare providers treat you with less respect or provide worse services to you compared to other people.	●	●	●	●	●	●

14. If you answered a few times a year or more, what do you think is the reason(s) for these experiences? You may select more than one.

    - Ableism (discrimination on the basis of disability)
    - Ageism (discrimination on the basis of age)
    - Discrimination based on income or education level
    - Discrimination on the basis of religion
    - Discrimination on the basis of weight or body size
    - Homophobia (discrimination against gay, lesbian, bisexual, or queer people)
    - Racism (discrimination on the basis of racial or ethnic group identity)
    - Sexism (discrimination on the basis of sex)
    - Transphobia (discrimination against transgender or gender non-binary people)
    - Xenophobia (discrimination against people born in another country)
    - Don't know
    - Prefer not to answer

15. The questions below are about changes happening in your community. We are interested to know if you feel you have a voice in changes that happen, and if these changes reflect what people who live, work, learn, and play here want. For each type of change that is happening in your community, please circle the responses that best describe your opinion.

	Are these changes happening in your community? **If NO, please skip to the next line.**	Do you feel like the average person in your community can influence these changes?	Do you think these changes will make your own life better?
Building new housing	▢ Yes ▢ No	▢ Yes ▢ No	▢ Yes ▢ No
Building or changing commercial spaces like shops, restaurants, or offices	▢ Yes ▢ No	▢ Yes ▢ No	▢ Yes ▢ No
Building or changing public spaces like libraries, parks, or community centers	▢ Yes ▢ No	▢ Yes ▢ No	▢ Yes ▢ No
Creating new jobs	▢ Yes ▢ No	▢ Yes ▢ No	▢ Yes ▢ No
Developing new transportation options	▢ Yes ▢ No	▢ Yes ▢ No	▢ Yes ▢ No
Changing police practices	▢ Yes ▢ No	▢ Yes ▢ No	▢ Yes ▢ No
Developing new grocery stores, markets, and urban agriculture	▢ Yes ▢ No	▢ Yes ▢ No	▢ Yes ▢ No

About You

The following questions help us to better understand how people of diverse identities and life experiences may have similar or different experiences of the community. **You may skip or leave blank any questions that you prefer not to answer.**

1. Many people feel a sense of belonging to communities other than the city or town where they spend the most time. Which of the following communities do you feel you belong to? (Please check all that apply.)
   - My neighborhood or building
   - Faith community (such as a place of worship or faith-based organization)
   - School community (such as an education program or school that you or your child attends)
   - Work community (such as your place of employment, or a professional association)
   - A shared identity or experience (such as a group of people who share an immigration experience, a racial or ethnic identity, a cultural heritage, or a gender identity)
   - A shared interest group (such as a club, sports team, political group, or advocacy group)
   - Another city or town where I do not live
   - Other (Feel free to share: _____)

2. How old are you? _____ (years)

3. What sex were you assigned at birth?
   - Female
   - Male

4. What is your current gender identity?
   - Genderqueer or gender non-conforming
   - Man
   - Transgender
   - Woman
   - Prefer to self-describe: _____

5. What is your sexual orientation?
   - Bisexual
   - Gay or lesbian
   - Straight/heterosexual
   - Prefer to self-describe: _____

6. Do you identify as a person with a disability?
   - Yes
   - No

7. Which of these groups best represents your race? (Please check all that apply.)
   - American Indian or Alaska Native
   - Asian
   - Black or African American
   - Hispanic/Latino
   - Native Hawaiian or Other Pacific Islander
   - White
   - Other (specify_____)

8. Which of these best represents your ethnicity? (Please check all that apply.)

- African (specify_____)
- African American
- American
- Brazilian
- Cambodian
- Cape Verdean
- Caribbean Islander (specify_____)
- Chinese
- Colombian
- Cuban
- Dominican
- European (specify _____)
- Filipino
- Guatemalan
- Haitian
- Honduran
- Indian
- Japanese
- Korean
- Laotian
- Mexican, Mexican-American, Chicano
- Middle Eastern (specify _____)
- Portuguese
- Puerto Rican
- Russian
- Salvadoran
- Vietnamese
- Other (specify_____)

9. What is the primary language(s) spoken in your home? (Please check all that apply).

- Arabic
- Cambodian/Khmer
- Cape Verdean Creole
- Chinese (including Mandarin or Cantonese)
- English
- French
- Haitian Creole
- Hindi
- Korean
- Portuguese
- Russian
- Spanish
- Vietnamese
- Other (specify_____

10. What is the highest grade or level of school that you have completed?

- Never attended school
- Grades 1–8 (less than high school)
- Grades 9–11 (some high school)
- Grade 12 (completed high school or GED)
- Associate's degree, technical/trade school
- College degree (Bachelor's)
- Graduate degree (Master's or Doctorate)

11. Are you currently:

- Employed full time
- Employed part time or seasor
- Self-employed (full or part tim
- A stay at home parent
- A student (full or part time)
- Out of work for more than 1 y
- Out of work for less than 1 ye
- Unable to work for health reas
- Retired
- Other (specify_____

12. Did you experience a change in employment due to the COVID-19 pandemic?

- Job loss (permanent or temporary)
- Reduced hours
- Took leave of absence (paid or unpaid)
- Nature of work changed (increased hours, change in role, new job, or working from home)
- No change in employment

13. How long have you lived in the United States?
    - Less than one year
    - 1 to 3 years
    - 4 to 6 years
    - More than 6 years, but not my whole life
    - I have always lived in the United States

14. Have you served on active duty in the U.S. A
    Reserves, or National Guard?
    - Never served in the military
    - On active duty now (in any branch)
    - On active duty in the past, but not now (
      retirement)

15. How would you describe your current housing situation?
    - I rent my home
    - I own my home
    - I am staying with another household
    - I am experiencing homelessness or staying in a shelter
    - Other (specify_____)

16. If you rent or own your home, who do you li
    - I live alone
    - Roommates or people I am not related
    - Spouse or domestic partner
    - My children or dependents
    - My parents
    - Other family or relatives
    - Other (specify_____)

17. Are you the parent or caregiver of a child under the age of 18?
    - Yes
    - No

    If yes, how old are the children you care for? (Please check all that apply.)

    - 0-3 years
    - 4-5 years
    - 6-10 years
    - 11-14 years
    - 15-17 years

18. Do you provide regular unpaid assistance c
    member or other dependent because of a h
    disability, or elderly age?
    - Yes
    - No

19. How would you describe your health in general?
    - Excellent
    - Very Good
    - Good
    - Fair
    - Poor

20. What kind of health insurance or health car
    have?
    - Free Care or Health Safety Net
    - Health Connector Plan that you purchas
    - Insurance through an employer or unior
    - MassHealth or ConnectorCare
    - Medicare
    - No health care coverage / Uninsured
    - Student health plan
    - Veterans Affairs, Military Health, or TRI
    - Other (specify_____)

Gift Card Drawing Information

If you would like to enter a drawing to win a $100 grocery gift card, please complete the form below to tell us the best way to contact you. This information will **not** be used to identify your responses to the survey. The drawing will take place in December.

Please return your completed survey and form to the place where you picked it up.

Thank you for your participation.

Gift Card Drawing Form

First Name: _____

Email Address or Phone number: _____

Your Community

In which community do you spend the most time?	
city	
Chelsea	493 (35%)
Revere	717 (51%)
Winthrop	191 (14%)
Total	1401 (100%)

How many years have you lived in this community?								
city	I have never lived here, but I work here	Less than 1 year	1-5 years	6-10 years	Over 10 years but not all my life	I have lived here all my life	NA_	Total
Chelsea	16 (3%)	28 (6%)	131 (27%)	104 (21%)	154 (31%)	60 (12%)	0 (0%)	493 (100%)
Revere	7 (1%)	17 (2%)	139 (19%)	167 (23%)	280 (39%)	99 (14%)	8 (1%)	717 (100%)
Winthrop	3 (2%)	4 (2%)	34 (18%)	51 (27%)	53 (28%)	45 (24%)	1 (1%)	191 (100%)
Total	26 (2%)	49 (3%)	304 (22%)	322 (23%)	487 (35%)	204 (15%)	9 (1%)	1401 (100%)

How many years have you worked in this community?							
city	I have never worked here, but I live here	Less than 1 year	1-5 years	6-10 years	Over 10 years	NA_	Total
Chelsea	50 (10%)	57 (12%)	190 (39%)	84 (17%)	110 (22%)	2 (0%)	493 (100%)
Revere	321 (45%)	33 (5%)	142 (20%)	96 (13%)	101 (14%)	24 (3%)	717 (100%)
Winthrop	101 (53%)	6 (3%)	38 (20%)	26 (14%)	18 (9%)	2 (1%)	191 (100%)
Total	472 (34%)	96 (7%)	370 (26%)	206 (15%)	229 (16%)	28 (2%)	1401 (100%)

Please select the response that best describes how much you agree or disagree with each statement about your community.							
I feel like I belong in my community.							
city	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	NA_	Total
Chelsea	136 (28%)	278 (56%)	7 (1%)	45 (9%)	24 (5%)	3 (1%)	493 (100%)
Revere	133 (19%)	501 (70%)	15 (2%)	45 (6%)	21 (3%)	2 (0%)	717 (100%)
Winthrop	22 (12%)	148 (77%)	3 (2%)	9 (5%)	3 (2%)	6 (3%)	191 (100%)
Total	291 (21%)	927 (66%)	25 (2%)	99 (7%)	48 (3%)	11 (1%)	1401 (100%)
Overall, I am satisfied with the quality of life in my community.							
city	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	NA_	Total
Chelsea	118 (24%)	278 (56%)	6 (1%)	70 (14%)	16 (3%)	5 (1%)	493 (100%)
Revere	118 (16%)	495 (69%)	10 (1%)	74 (10%)	15 (2%)	5 (1%)	717 (100%)
Winthrop	28 (15%)	143 (75%)	1 (1%)	7 (4%)	2 (1%)	10 (5%)	191 (100%)
Total	264 (19%)	916 (65%)	17 (1%)	151 (11%)	33 (2%)	20 (1%)	1401 (100%)
My community is a good place to raise children.							
city	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	NA_	Total
Chelsea	106 (22%)	283 (57%)	22 (4%)	63 (13%)	16 (3%)	3 (1%)	493 (100%)
Revere	111 (15%)	503 (70%)	17 (2%)	65 (9%)	15 (2%)	6 (1%)	717 (100%)

Winthrop	23 (12%)	142 (74%)	10 (5%)	7 (4%)	1 (1%)	8 (4%)	191 (100%)
Total	240 (17%)	928 (66%)	49 (3%)	135 (10%)	32 (2%)	17 (1%)	1401 (100%)
My community is a good place to grow old.							
city	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	NA_	Total
Chelsea	110 (22%)	272 (55%)	24 (5%)	67 (14%)	18 (4%)	2 (0%)	493 (100%)
Revere	123 (17%)	470 (66%)	30 (4%)	68 (9%)	20 (3%)	6 (1%)	717 (100%)
Winthrop	24 (13%)	143 (75%)	8 (4%)	6 (3%)	1 (1%)	9 (5%)	191 (100%)
Total	257 (18%)	885 (63%)	62 (4%)	141 (10%)	39 (3%)	17 (1%)	1401 (100%)
My community has good access to resources.							
city	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	NA_	Total
Chelsea	125 (25%)	289 (59%)	9 (2%)	53 (11%)	12 (2%)	5 (1%)	493 (100%)
Revere	123 (17%)	487 (68%)	20 (3%)	60 (8%)	22 (3%)	5 (1%)	717 (100%)
Winthrop	19 (10%)	146 (76%)	3 (2%)	11 (6%)	2 (1%)	10 (5%)	191 (100%)
Total	267 (19%)	922 (66%)	32 (2%)	124 (9%)	36 (3%)	20 (1%)	1401 (100%)

What are the most important things you would like to improve about your community? Please select up to 5 items from the list below.			
	Chelsea	Revere	Winthrop
Better access to good jobs	144 (30.7%)	155 (23.4%)	26 (13.6%)
Better access to health care	242 (51.6%)	217 (32.8%)	49 (25.7%)
Better access to healthy food	112 (23.9%)	132 (19.9%)	37 (19.4%)
Better access to internet	68 (14.5%)	85 (12.8%)	14 (7.3%)
Better access to public transportation	135 (28.8%)	137 (20.7%)	43 (22.5%)
Better parks and recreation opportunities	92 (19.6%)	159 (24%)	24 (12.6%)
Better preparedness for extreme weather (like heat waves and floods)	40 (8.5%)	67 (10.1%)	12 (6.3%)
Better roads and transit infrastructure	94 (20%)	206 (31.1%)	53 (27.7%)
Better schools	225 (48%)	286 (43.2%)	99 (51.8%)
Better sidewalks and trails	48 (10.2%)	146 (22.1%)	34 (17.8%)
Cleaner environment	161 (34.3%)	171 (25.8%)	44 (23%)
Lower crime and violence	241 (51.4%)	266 (40.2%)	96 (50.3%)
More affordable childcare	94 (20%)	109 (16.5%)	28 (14.7%)
More affordable housing	254 (54.2%)	460 (69.5%)	54 (28.3%)
More arts and cultural events	72 (15.4%)	137 (20.7%)	28 (14.7%)
More effective city services (like water, trash, fire and police services)	93 (19.8%)	100 (15.1%)	37 (19.4%)
More respect and inclusion for diverse members of the community	69 (14.7%)	103 (15.6%)	39 (20.4%)
Stronger community leadership	38 (8.1%)	68 (10.3%)	25 (13.1%)
Stronger sense of community	39 (8.3%)	83 (12.5%)	23 (12%)
Total	469	662	191

Natural and Built Environment

The natural and built environment impacts the health and wellbeing of people and communities. For each statement below, choose the response that best describes how true you think it is.						
My community feels inviting and safe.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	278 (56%)	165 (33%)	7 (1%)	39 (8%)	4 (1%)	493 (100%)
Revere	427 (60%)	243 (34%)	12 (2%)	33 (5%)	2 (0%)	717 (100%)
Winthrop	103 (54%)	73 (38%)	2 (1%)	8 (4%)	5 (3%)	191 (100%)
Total	808 (58%)	481 (34%)	21 (1%)	80 (6%)	11 (1%)	1401 (100%)
People like me have access to reliable transportation.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	341 (69%)	128 (26%)	5 (1%)	14 (3%)	5 (1%)	493 (100%)
Revere	484 (68%)	193 (27%)	15 (2%)	18 (3%)	7 (1%)	717 (100%)
Winthrop	133 (70%)	41 (21%)	2 (1%)	4 (2%)	11 (6%)	191 (100%)
Total	958 (68%)	362 (26%)	22 (2%)	36 (3%)	23 (2%)	1401 (100%)
People like me have housing that is safe and good quality.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	301 (61%)	131 (27%)	12 (2%)	39 (8%)	10 (2%)	493 (100%)
Revere	438 (61%)	203 (28%)	20 (3%)	50 (7%)	6 (1%)	717 (100%)
Winthrop	138 (72%)	33 (17%)	3 (2%)	2 (1%)	15 (8%)	191 (100%)
Total	877 (63%)	367 (26%)	35 (2%)	91 (6%)	31 (2%)	1401 (100%)
The air in my community is healthy to breathe.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	283 (57%)	109 (22%)	35 (7%)	55 (11%)	11 (2%)	493 (100%)
Revere	422 (59%)	201 (28%)	37 (5%)	53 (7%)	4 (1%)	717 (100%)
Winthrop	127 (66%)	32 (17%)	4 (2%)	15 (8%)	13 (7%)	191 (100%)

Total	832 (59%)	342 (24%)	76 (5%)	123 (9%)	28 (2%)	1401 (100%)
The water in my community is safe to drink.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	302 (61%)	112 (23%)	55 (11%)	24 (5%)	0 (0%)	493 (100%)
Revere	432 (60%)	174 (24%)	75 (10%)	32 (4%)	4 (1%)	717 (100%)
Winthrop	136 (71%)	29 (15%)	5 (3%)	5 (3%)	16 (8%)	191 (100%)
Total	870 (62%)	315 (22%)	135 (10%)	61 (4%)	20 (1%)	1401 (100%)
During extreme heat, people like me have access to options for staying cool.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	294 (60%)	152 (31%)	23 (5%)	17 (3%)	7 (1%)	493 (100%)
Revere	423 (59%)	198 (28%)	34 (5%)	55 (8%)	7 (1%)	717 (100%)
Winthrop	127 (66%)	46 (24%)	4 (2%)	3 (2%)	11 (6%)	191 (100%)
Total	844 (60%)	396 (28%)	61 (4%)	75 (5%)	25 (2%)	1401 (100%)
My community is prepared to protect ourselves during climate disasters, such as flash flooding, hurricanes, or blizzards.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	263 (53%)	129 (26%)	64 (13%)	31 (6%)	6 (1%)	493 (100%)
Revere	370 (52%)	203 (28%)	83 (12%)	56 (8%)	5 (1%)	717 (100%)
Winthrop	116 (61%)	34 (18%)	19 (10%)	9 (5%)	13 (7%)	191 (100%)
Total	749 (53%)	366 (26%)	166 (12%)	96 (7%)	24 (2%)	1401 (100%)
People like me have access to safe, clean parks and open spaces.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	305 (62%)	149 (30%)	5 (1%)	29 (6%)	5 (1%)	493 (100%)
Revere	446 (62%)	224 (31%)	9 (1%)	32 (4%)	6 (1%)	717 (100%)
Winthrop	143 (75%)	36 (19%)	0 (0%)	4 (2%)	8 (4%)	191 (100%)
Total	894 (64%)	409 (29%)	14 (1%)	65 (5%)	19 (1%)	1401 (100%)

Economic and Education Environment

The economic and educational environment impacts the health and wellbeing of people and communities. For each statement below, choose the response that best describes how true you think it is.

People like me have access to good local jobs with living wages and benefits.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	207 (42%)	145 (29%)	14 (3%)	122 (25%)	5 (1%)	493 (100%)
Revere	167 (23%)	172 (24%)	57 (8%)	314 (44%)	7 (1%)	717 (100%)
Winthrop	88 (46%)	62 (32%)	1 (1%)	10 (5%)	30 (16%)	191 (100%)
Total	462 (33%)	379 (27%)	72 (5%)	446 (32%)	42 (3%)	1401 (100%)
People like me have access to local investment opportunities, such as owning homes or businesses.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	211 (43%)	117 (24%)	26 (5%)	126 (26%)	13 (3%)	493 (100%)
Revere	165 (23%)	178 (25%)	50 (7%)	319 (44%)	5 (1%)	717 (100%)
Winthrop	88 (46%)	58 (30%)	3 (2%)	10 (5%)	32 (17%)	191 (100%)
Total	464 (33%)	353 (25%)	79 (6%)	455 (32%)	50 (4%)	1401 (100%)
Housing in my community is affordable for people like me.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	207 (42%)	119 (24%)	10 (2%)	142 (29%)	15 (3%)	493 (100%)
Revere	156 (22%)	156 (22%)	31 (4%)	364 (51%)	10 (1%)	717 (100%)
Winthrop	81 (42%)	59 (31%)	2 (1%)	14 (7%)	35 (18%)	191 (100%)
Total	444 (32%)	334 (24%)	43 (3%)	520 (37%)	60 (4%)	1401 (100%)
People like me have access to affordable child care services.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	199 (40%)	122 (25%)	42 (9%)	117 (24%)	13 (3%)	493 (100%)
Revere	141 (20%)	155 (22%)	98 (14%)	314 (44%)	9 (1%)	717 (100%)
Winthrop	85 (45%)	50 (26%)	10 (5%)	10 (5%)	36 (19%)	191 (100%)

Total	425 (30%)	327 (23%)	150 (11%)	441 (31%)	58 (4%)	1401 (100%)
People like me have access to good education for their children.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	242 (49%)	130 (26%)	29 (6%)	88 (18%)	4 (1%)	493 (100%)
Revere	228 (32%)	169 (24%)	48 (7%)	262 (37%)	10 (1%)	717 (100%)
Winthrop	85 (45%)	54 (28%)	10 (5%)	7 (4%)	35 (18%)	191 (100%)
Total	555 (40%)	353 (25%)	87 (6%)	357 (25%)	49 (3%)	1401 (100%)

Health and Access to Care

The healthcare environment impacts the health and wellbeing of people and communities. For each statement below, choose the response that best describes how true you think it is.						
Health care in my community meets the physical health needs of people like me.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	268 (54%)	158 (32%)	12 (2%)	55 (11%)	0 (0%)	493 (100%)
Revere	272 (38%)	257 (36%)	30 (4%)	143 (20%)	15 (2%)	717 (100%)
Winthrop	73 (38%)	54 (28%)	1 (1%)	10 (5%)	53 (28%)	191 (100%)
Total	613 (44%)	469 (33%)	43 (3%)	208 (15%)	68 (5%)	1401 (100%)
Health care in my community meets the mental health needs of people like me.						
city	True	Sometimes true	Don't know	Not at all true	NA_	Total
Chelsea	184 (37%)	144 (29%)	35 (7%)	55 (11%)	75 (15%)	493 (100%)
Revere	164 (23%)	209 (29%)	74 (10%)	162 (23%)	108 (15%)	717 (100%)
Winthrop	58 (30%)	49 (26%)	12 (6%)	18 (9%)	54 (28%)	191 (100%)
Total	406 (29%)	402 (29%)	121 (9%)	235 (17%)	237 (17%)	1401 (100%)

In the last 12 months, did you ever need any of the following types of health care? Please select the response that best describes your experience.					
Dental (mouth) care					
city	I needed this type of care and was able to access it.	I did not need this type of care	I needed this type of care but could not access it.	NA_	Total
Chelsea	248 (50%)	50 (10%)	191 (39%)	4 (1%)	493 (100%)
Revere	366 (51%)	110 (15%)	209 (29%)	32 (4%)	717 (100%)
Winthrop	145 (76%)	17 (9%)	27 (14%)	2 (1%)	191 (100%)
Total	759 (54%)	177 (13%)	427 (29%)	38 (3%)	1401 (100%)

Emergency care for mental health crisis, including suicidal thoughts					
city	I needed this type of care and was able to access it.	I did not need this type of care	I needed this type of care but could not access it.	NA_	Total
Chelsea	84 (17%)	178 (36%)	51 (10%)	180 (37%)	493 (100%)
Revere	77 (11%)	287 (40%)	59 (8%)	294 (41%)	717 (100%)
Winthrop	28 (15%)	70 (37%)	15 (8%)	78 (41%)	191 (100%)
Total	189 (13%)	535 (38%)	125 (9%)	552 (39%)	1401 (100%)
Medication for a chronic illness					
city	I needed this type of care and was able to access it.	I did not need this type of care	I needed this type of care but could not access it.	NA_	Total
Chelsea	101 (20%)	149 (30%)	61 (12%)	182 (37%)	493 (100%)
Revere	142 (20%)	215 (30%)	64 (9%)	296 (41%)	717 (100%)
Winthrop	44 (23%)	52 (27%)	17 (9%)	78 (41%)	191 (100%)
Total	287 (20%)	416 (30%)	142 (10%)	556 (40%)	1401 (100%)
Mental health care					
city	I needed this type of care and was able to access it.	I did not need this type of care	I needed this type of care but could not access it.	NA_	Total
Chelsea	102 (21%)	133 (27%)	75 (15%)	183 (37%)	493 (100%)
Revere	115 (16%)	232 (32%)	80 (12%)	290 (40%)	717 (100%)
Winthrop	30 (16%)	45 (24%)	37 (20%)	79 (41%)	191 (100%)
Total	247 (18%)	410 (29%)	192 (13%)	552 (39%)	1401 (100%)
Reproductive health care					
city	I needed this type of care and was able to access it.	I did not need this type of care	I needed this type of care but could not access it.	NA_	Total
Chelsea	93 (19%)	170 (34%)	49 (10%)	181 (37%)	493 (100%)

Revere	108 (15%)	257 (36%)	56 (8%)	296 (41%)	717 (100%)
Winthrop	36 (19%)	54 (28%)	23 (13%)	78 (41%)	191 (100%)
Total	237 (17%)	481 (34%)	128 (9%)	555 (40%)	1401 (100%)
Treatment for a substance use disorder					
city	I needed this type of care and was able to access it.	I did not need this type of care	I needed this type of care but could not access it.	NA_	Total
Chelsea	71 (14%)	177 (36%)	62 (13%)	183 (37%)	493 (100%)
Revere	73 (10%)	298 (42%)	52 (7%)	294 (41%)	717 (100%)
Winthrop	44 (23%)	48 (25%)	21 (11%)	78 (41%)	191 (100%)
Total	188 (13%)	523 (37%)	135 (9%)	555 (40%)	1401 (100%)
Vision care					
city	I needed this type of care and was able to access it.	I did not need this type of care	I needed this type of care but could not access it.	NA_	Total
Chelsea	205 (42%)	106 (22%)	154 (32%)	28 (6%)	493 (100%)
Revere	322 (45%)	158 (22%)	150 (21%)	87 (12%)	717 (100%)
Winthrop	147 (77%)	28 (15%)	16 (9%)	0 (0%)	191 (100%)
Total	674 (48%)	292 (21%)	320 (23%)	115 (8%)	1401 (100%)

For any types of care that you needed but were not able to access, select the reason(s) why you were unable to access care. You may select more than one.								
Dental (mouth) care								
city	Another reason not listed here	Concern about COVID exposure	Fear or distrust of the health care system	Hours did not fit my schedule	No providers speak my language	Unable to afford the costs	Unable to get transportation	Total
Chelsea	6 (3%)	19 (8%)	13 (6%)	23 (10%)	5 (2%)	146 (63%)	21 (9%)	233 (100%)
Revere	8 (3%)	34 (12%)	20 (7%)	20 (7%)	11 (4%)	155 (57%)	25 (9%)	273 (100%)
Winthrop	4 (7%)	16 (28%)	7 (12%)	8 (14%)	4 (7%)	12 (21%)	7 (12%)	58 (100%)
Total	18 (3%)	69 (12%)	40 (7%)	51 (9%)	20 (4%)	313 (55%)	53 (9%)	564 (100%)
Emergency care for mental health crisis, including suicidal thoughts								
city	Another reason not listed here	Concern about COVID exposure	Fear or distrust of the health care system	Hours did not fit my schedule	No providers speak my language	Unable to afford the costs	Unable to get transportation	Total
Chelsea	6 (8%)	8 (10%)	13 (16%)	15 (19%)	3 (4%)	23 (29%)	12 (15%)	80 (100%)
Revere	5 (4%)	13 (11%)	19 (16%)	13 (11%)	10 (9%)	43 (37%)	14 (12%)	117 (100%)
Winthrop	1 (4%)	4 (17%)	5 (22%)	6 (26%)	2 (9%)	3 (13%)	2 (9%)	23 (100%)
Total	12 (5%)	25 (11%)	37 (17%)	34 (15%)	15 (7%)	69 (31%)	28 (13%)	220 (100%)
Medication for a chronic illness								
city	Another reason not listed here	Concern about COVID exposure	Fear or distrust of the health care system	Hours did not fit my schedule	No providers speak my language	Unable to afford the costs	Unable to get transportation	Total

Chelsea	1 (1%)	6 (7%)	16 (18%)	21 (23%)	6 (7%)	23 (25%)	18 (20%)	91 (100%)
Revere	4 (3%)	11 (9%)	19 (16%)	26 (22%)	7 (6%)	27 (23%)	26 (22%)	120 (100%)
Winthrop	0 (0%)	7 (18%)	5 (13%)	10 (26%)	1 (3%)	10 (26%)	5 (13%)	38 (100%)
Total	5 (2%)	24 (10%)	40 (16%)	57 (23%)	14 (6%)	60 (24%)	49 (20%)	249 (100%)
Mental health care								
city	Another reason not listed here	Concern about COVID exposure	Fear or distrust of the health care system	Hours did not fit my schedule	No providers speak my language	Unable to afford the costs	Unable to get transportation	Total
Chelsea	8 (7%)	7 (6%)	16 (14%)	30 (27%)	7 (6%)	17 (15%)	27 (24%)	112 (100%)
Revere	15 (10%)	15 (10%)	17 (12%)	34 (23%)	12 (8%)	29 (20%)	25 (17%)	147 (100%)
Winthrop	8 (11%)	10 (14%)	11 (15%)	14 (20%)	6 (8%)	11 (15%)	11 (15%)	71 (100%)
Total	31 (9%)	32 (10%)	44 (13%)	78 (24%)	25 (8%)	57 (17%)	63 (19%)	330 (100%)
Reproductive health care								
city	Another reason not listed here	Concern about COVID exposure	Fear or distrust of the health care system	Hours did not fit my schedule	No providers speak my language	Unable to afford the costs	Unable to get transportation	Total
Chelsea	1 (2%)	6 (11%)	13 (23%)	11 (19%)	7 (12%)	10 (18%)	9 (16%)	57 (100%)
Revere	5 (6%)	8 (9%)	18 (20%)	20 (22%)	7 (8%)	16 (18%)	15 (17%)	89 (100%)
Winthrop	2 (6%)	1 (3%)	8 (25%)	7 (22%)	3 (9%)	6 (19%)	5 (16%)	32 (100%)
Total	8 (4%)	15 (8%)	39 (22%)	38 (21%)	17 (10%)	32 (18%)	29 (16%)	178 (100%)
Treatment for a substance use disorder								

city	Another reason not listed here	Concern about COVID exposure	Fear or distrust of the health care system	Hours did not fit my schedule	No providers speak my language	Unable to afford the costs	Unable to get transportation	Total
Chelsea	4 (4%)	8 (8%)	16 (17%)	25 (26%)	6 (6%)	19 (20%)	18 (19%)	96 (100%)
Revere	2 (2%)	8 (8%)	20 (21%)	17 (18%)	15 (16%)	15 (16%)	19 (20%)	96 (100%)
Winthrop	0 (0%)	3 (8%)	7 (19%)	8 (22%)	0 (0%)	10 (28%)	8 (22%)	36 (100%)
Total	6 (3%)	19 (8%)	43 (19%)	50 (22%)	21 (9%)	44 (19%)	45 (20%)	228 (100%)
Vision care								
city	Another reason not listed here	Concern about COVID exposure	Fear or distrust of the health care system	Hours did not fit my schedule	No providers speak my language	Unable to afford the costs	Unable to get transportation	Total
Chelsea	8 (5%)	6 (4%)	17 (10%)	19 (11%)	9 (5%)	96 (56%)	15 (9%)	170 (100%)
Revere	19 (10%)	12 (6%)	12 (6%)	24 (12%)	9 (5%)	91 (47%)	26 (13%)	193 (100%)
Winthrop	2 (9%)	7 (30%)	2 (9%)	3 (13%)	2 (9%)	6 (26%)	1 (4%)	23 (100%)
Total	29 (8%)	25 (6%)	31 (8%)	46 (12%)	20 (5%)	193 (50%)	42 (11%)	386 (100%)

Social and Cultural Environment

The questions below are about changes happening in your community. We are interested to know if you feel you have a voice in changes that happen, and if these changes reflect what people who live, work, learn, and play here want. Which of the changes described below are happening in your community? You may select more than one.				
	Chelsea	Revere	Winthrop	Total
Building new housing	316 (27%)	425 (34%)	56 (19%)	797 (29%)
Building or changing commercial spaces like shops, restaurants, or offices	182 (16%)	221 (18%)	68 (23%)	471 (17%)
Building or changing public spaces like libraries, parks, or community centers	175 (15%)	191 (15%)	64 (22%)	430 (16%)
Changing police practices	73 (6%)	79 (6%)	15 (5%)	167 (6%)
Creating new jobs	185 (16%)	165 (13%)	38 (13%)	388 (14%)
Developing new grocery stores, markets, and urban agriculture	110 (9%)	85 (7%)	19 (6%)	214 (8%)
Developing new transportation options	124 (11%)	96 (8%)	35 (12%)	255 (9%)
Total	1165 (100%)	1262 (100%)	295 (100%)	2722 (100%)

For each type of change that is happening, do you feel like the average person in your community can influence these changes?						For each type of change that is happening, do you think these changes will make your own life better?				
Build new housing						**Build new housing**				
city	No	Yes	NA_	Total		city	No	Yes	NA_	Total
Chelsea	110 (22%)	205 (42%)	178 (36%)	493 (100%)		Chelsea	104 (21%)	211 (43%)	178 (36%)	493 (100%)
Revere	215 (30%)	208 (29%)	294 (41%)	717 (100%)		Revere	208 (29%)	214 (30%)	295 (41%)	717 (100%)
Winthrop	27 (14%)	29 (15%)	135 (71%)	191 (100%)		Winthrop	28 (15%)	28 (15%)	135 (71%)	191 (100%)
Total	352 (25%)	442 (32%)	607 (43%)	1401 (100%)		Total	340 (24%)	453 (32%)	608 (43%)	1401 (100%)

Building or changing commercial spaces like shops, restaurants, or offices						Building or changing commercial spaces like shops, restaurants, or offices				
city	No	Yes	NA_	Total		city	No	Yes	NA_	Total
Chelsea	52 (11%)	130 (26%)	311 (63%)	493 (100%)		Chelsea	34 (7%)	147 (30%)	312 (63%)	493 (100%)
Revere	104 (15%)	114 (16%)	499 (70%)	717 (100%)		Revere	58 (8%)	155 (22%)	504 (70%)	717 (100%)
Winthrop	15 (8%)	53 (28%)	123 (64%)	191 (100%)		Winthrop	12 (6%)	56 (29%)	123 (64%)	191 (100%)
Total	171 (12%)	297 (21%)	933 (67%)	1401 (100%)		Total	104 (7%)	358 (26%)	939 (67%)	1401 (100%)
Building or changing public spaces like libraries, parks, or community centers						Building or changing public spaces like libraries, parks, or community centers				
city	No	Yes	NA_	Total		city	No	Yes	NA_	Total
Chelsea	36 (7%)	137 (28%)	320 (65%)	493 (100%)		Chelsea	32 (6%)	142 (29%)	319 (65%)	493 (100%)
Revere	50 (7%)	139 (19%)	528 (74%)	717 (100%)		Revere	28 (4%)	160 (22%)	529 (74%)	717 (100%)
Winthrop	11 (6%)	53 (28%)	127 (66%)	191 (100%)		Winthrop	7 (4%)	57 (30%)	127 (66%)	191 (100%)
Total	97 (7%)	329 (23%)	975 (70%)	1401 (100%)		Total	67 (5%)	359 (26%)	975 (70%)	1401 (100%)
Creating new jobs						Creating new jobs				
city	No	Yes	NA_	Total		city	No	Yes	NA_	Total
Chelsea	48 (10%)	134 (27%)	311 (63%)	493 (100%)		Chelsea	42 (9%)	142 (29%)	309 (63%)	493 (100%)
Revere	57 (8%)	107 (15%)	553 (77%)	717 (100%)		Revere	27 (4%)	136 (19%)	554 (77%)	717 (100%)
Winthrop	8 (4%)	30 (16%)	153 (80%)	191 (100%)		Winthrop	5 (3%)	33 (17%)	153 (80%)	191 (100%)
Total	113 (8%)	271 (19%)	1017 (73%)	1401 (100%)		Total	74 (5%)	311 (22%)	1016 (73%)	1401 (100%)

Developing new transportation options						Developing new transportation options				
city	No	Yes	NA_	Total		city	No	Yes	NA_	Total
Chelsea	41 (8%)	80 (16%)	372 (75%)	493 (100%)		Chelsea	19 (4%)	101 (20%)	373 (76%)	493 (100%)
Revere	40 (6%)	55 (8%)	622 (87%)	717 (100%)		Revere	23 (3%)	72 (10%)	622 (87%)	717 (100%)
Winthrop	6 (3%)	29 (15%)	156 (82%)	191 (100%)		Winthrop	9 (5%)	26 (14%)	156 (82%)	191 (100%)
Total	87 (6%)	164 (12%)	1150 (82%)	1401 (100%)		Total	51 (4%)	199 (14%)	1151 (82%)	1401 (100%)
Changing police practices						**Changing police practices**				
city	No	Yes	NA_	Total		city	No	Yes	NA_	Total
Chelsea	38 (8%)	34 (7%)	421 (85%)	493 (100%)		Chelsea	31 (6%)	41 (8%)	421 (85%)	493 (100%)
Revere	30 (4%)	48 (7%)	639 (89%)	717 (100%)		Revere	18 (3%)	61 (9%)	638 (89%)	717 (100%)
Winthrop	4 (2%)	11 (6%)	176 (92%)	191 (100%)		Winthrop	3 (2%)	12 (6%)	176 (92%)	191 (100%)
Total	72 (5%)	93 (7%)	1236 (88%)	1401 (100%)		Total	52 (4%)	114 (8%)	1235 (88%)	1401 (100%)
Developing new grocery stores, markets, and urban agriculture						**Developing new grocery stores, markets, and urban agriculture**				
city	No	Yes	NA_	Total		city	No	Yes	NA_	Total
Chelsea	45 (9%)	60 (12%)	388 (79%)	493 (100%)		Chelsea	46 (9%)	63 (13%)	384 (78%)	493 (100%)
Revere	37 (5%)	48 (7%)	632 (88%)	717 (100%)		Revere	18 (3%)	67 (9%)	632 (88%)	717 (100%)
Winthrop	2 (1%)	17 (9%)	172 (90%)	191 (100%)		Winthrop	1 (1%)	18 (9%)	172 (90%)	191 (100%)
Total	84 (6%)	125 (9%)	1192 (85%)	1401 (100%)		Total	65 (5%)	148 (11%)	1188 (85%)	1401 (100%)

If you answered a few times a year or more, what do you think is the reason(s) for these experiences? You may select more than one.			
	Chelsea	Revere	Winthrop
Ableism (discrimination on the basis of disability)	31 (7.5%)	27 (5%)	8 (7.2%)
Ageism (discrimination on the basis of age)	66 (16.1%)	71 (13.2%)	23 (20.7%)
Discrimination based on income or education level	93 (22.6%)	89 (16.5%)	31 (27.9%)
Discrimination on the basis of religion	53 (12.9%)	60 (11.2%)	26 (23.4%)
Discrimination on the basis of weight or body size	51 (12.4%)	62 (11.5%)	26 (23.4%)
Don't know	229 (55.7%)	366 (68%)	41 (36.9%)
Homophobia (discrimination against gay, lesbian, bisexual, or queer people)	35 (8.5%)	34 (6.3%)	19 (17.1%)
Racism (discrimination on the basis of racial or ethnic group identity)	81 (19.7%)	94 (17.5%)	29 (26.1%)
Sexism (discrimination on the basis of sex)	31 (7.5%)	44 (8.2%)	20 (18%)
Transphobia (discrimination against transgender or gender non-binary people)	11 (2.7%)	20 (3.7%)	4 (3.6%)
Xenophobia (discrimination against people born in another country)	34 (8.3%)	35 (6.5%)	16 (14.4%)
Total	411	538	111

Discrimination negatively impacts the health and wellbeing of people and communities. We are interested in the ways you are treated in your community. For each of the statements below, please check the response that best describes how often each experience happens to you.								
You are not hired for jobs for unfair reasons, are unfairly fired, or are denied a raise.								
city	Less than once a year	A few times a year	A few times a month	At least once a week	Almost every day	Never	NA_	Total
Chelsea	73 (15%)	52 (11%)	18 (4%)	5 (1%)	3 (1%)	328 (67%)	14 (3%)	493 (100%)
Revere	73 (10%)	59 (8%)	13 (2%)	2 (0%)	8 (1%)	543 (76%)	19 (3%)	717 (100%)
Winthrop	40 (21%)	9 (5%)	0 (0%)	0 (0%)	0 (0%)	133 (70%)	9 (5%)	191 (100%)
Total	186 (13%)	120 (9%)	31 (2%)	7 (0%)	11 (1%)	1004 (72%)	42 (3%)	1401 (100%)
You are unfairly stopped, searched, questioned, threatened, or abused by the police.								

city	Less than once a year	A few times a year	A few times a month	At least once a week	Almost every day	Never	NA_	Total
Chelsea	57 (12%)	36 (7%)	21 (4%)	4 (1%)	0 (0%)	360 (73%)	15 (3%)	493 (100%)
Revere	68 (9%)	33 (5%)	9 (1%)	4 (1%)	0 (0%)	592 (83%)	11 (2%)	717 (100%)
Winthrop	25 (13%)	17 (9%)	2 (1%)	1 (1%)	0 (0%)	132 (69%)	14 (7%)	191 (100%)
Total	150 (11%)	86 (6%)	32 (2%)	9 (1%)	0 (0%)	1084 (77%)	40 (3%)	1401 (100%)
You receive worse service than other people at stores, restaurants, or service providers.								
city	Less than once a year	A few times a year	A few times a month	At least once a week	Almost every day	Never	NA_	Total
Chelsea	65 (13%)	61 (12%)	26 (5%)	7 (1%)	1 (0%)	321 (65%)	12 (2%)	493 (100%)
Revere	75 (10%)	66 (9%)	26 (4%)	3 (0%)	4 (1%)	525 (73%)	18 (3%)	717 (100%)
Winthrop	29 (15%)	14 (7%)	4 (2%)	1 (1%)	0 (0%)	127 (66%)	16 (8%)	191 (100%)
Total	169 (12%)	141 (10%)	56 (4%)	11 (1%)	5 (0%)	973 (69%)	46 (3%)	1401 (100%)
Landlords or realtors refuse to rent or sell you an apartment or house.								
city	Less than once a year	A few times a year	A few times a month	At least once a week	Almost every day	Never	NA_	Total
Chelsea	44 (9%)	47 (10%)	17 (3%)	7 (1%)	2 (0%)	364 (74%)	12 (2%)	493 (100%)
Revere	57 (8%)	38 (5%)	10 (1%)	5 (1%)	2 (0%)	588 (82%)	17 (2%)	717 (100%)
Winthrop	25 (13%)	13 (7%)	1 (1%)	0 (0%)	0 (0%)	134 (70%)	18 (9%)	191 (100%)
Total	126 (9%)	98 (7%)	28 (2%)	12 (1%)	4 (0%)	1086 (78%)	47 (3%)	1401 (100%)
Healthcare providers treat you with less respect or provide worse services to you compared to other people.								
city	Less than once a year	A few times a year	A few times a month	At least once a week	Almost every day	Never	NA_	Total

Chelsea	63 (13%)	47 (10%)	19 (4%)	6 (1%)	1 (0%)	352 (71%)	5 (1%)	493 (100%)
Revere	52 (7%)	46 (6%)	20 (3%)	5 (1%)	5 (1%)	575 (80%)	14 (2%)	717 (100%)
Winthrop	24 (13%)	13 (7%)	3 (2%)	1 (1%)	0 (0%)	133 (70%)	17 (9%)	191 (100%)
Total	139 (10%)	106 (8%)	42 (3%)	12 (1%)	6 (0%)	1060 (76%)	36 (3%)	1401 (100%)

There are people and/or organizations in my community that support me during times of stress and need.							
city	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	NA_	Total
Chelsea	117 (24%)	301 (61%)	17 (3%)	33 (7%)	20 (4%)	5 (1%)	493 (100%)
Revere	54 (8%)	307 (43%)	97 (14%)	99 (14%)	148 (21%)	12 (2%)	717 (100%)
Winthrop	12 (6%)	97 (51%)	14 (7%)	20 (10%)	6 (3%)	42 (22%)	191 (100%)
Total	183 (13%)	705 (50%)	128 (9%)	152 (11%)	174 (12%)	59 (4%)	1401 (100%)
I believe that all residents, including myself, can make the community a better place to live.							
city	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	NA_	Total
Chelsea	165 (33%)	277 (56%)	9 (2%)	31 (6%)	5 (1%)	6 (1%)	493 (100%)
Revere	162 (23%)	324 (45%)	17 (2%)	67 (9%)	136 (19%)	11 (2%)	717 (100%)
Winthrop	32 (17%)	94 (49%)	1 (1%)	14 (7%)	7 (4%)	43 (23%)	191 (100%)
Total	359 (26%)	695 (50%)	27 (2%)	112 (8%)	148 (11%)	60 (4%)	1401 (100%)

During COVID-19, information I need to stay healthy and safe has been readily available in my community.							
city	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	NA_	Total
Chelsea	156 (32%)	287 (58%)	15 (3%)	28 (6%)	4 (1%)	3 (1%)	493 (100%)
Revere	134 (19%)	324 (45%)	22 (3%)	85 (12%)	138 (19%)	14 (2%)	717 (100%)
Winthrop	26 (14%)	102 (53%)	1 (1%)	16 (8%)	9 (5%)	37 (19%)	191 (100%)
Total	316 (23%)	713 (51%)	38 (3%)	129 (9%)	151 (11%)	54 (4%)	1401 (100%)

During COVID-19, resources I need to stay healthy and safe have been readily available in my community.							
city	Strongly Agree	Agree	Don't Know	Disagree	Strongly Disagree	NA_	Total
Chelsea	156 (32%)	287 (58%)	15 (3%)	28 (6%)	4 (1%)	3 (1%)	493 (100%)
Revere	134 (19%)	324 (45%)	22 (3%)	85 (12%)	138 (19%)	14 (2%)	717 (100%)
Winthrop	26 (14%)	102 (53%)	1 (1%)	16 (8%)	9 (5%)	37 (19%)	191 (100%)
Total	316 (23%)	713 (51%)	38 (3%)	129 (9%)	151 (11%)	54 (4%)	1401 (100%)

About You

Many people feel a sense of belonging to communities other than the city or town where they spend the most time. Which of the following communities do you feel you belong to? (Please check all that apply.)			
	Chelsea	Revere	Winthrop
A shared identity or experience (such as a group of people who share an immigration experience, a racial or ethnic identity, a cultural heritage, or a gender identity)	94 (20.4%)	130 (20.2%)	46 (25%)
A shared interest group (such as a club, sports team, political group, or advocacy group)	79 (17.2%)	107 (16.6%)	46 (25%)
Another city or town where I do not live	20 (4.3%)	43 (6.7%)	4 (2.2%)
Faith community (such as a place of worship or faith-based organization)	102 (22.2%)	105 (16.3%)	26 (14.1%)
My neighborhood or building	326 (70.9%)	491 (76.1%)	129 (70.1%)
School community (such as an education program or school that you or your child attends)	124 (27%)	129 (20%)	42 (22.8%)
Work community (such as your place of employment, or a professional association)	155 (33.7%)	165 (25.6%)	69 (37.5%)
Total	460	645	184

How old are you?				
	Chelsea	Revere	Winthrop	Total
5-11 Years	0 (0%)	0 (0%)	0 (0%)	0 (0%)
12-15 Years	11 (2%)	0 (0%)	0 (0%)	11 (1%)
16-19 Years	7 (1%)	10 (1%)	1 (1%)	18 (1%)
20-29 Years	130 (26%)	102 (14%)	51 (27%)	283 (20%)
30-49 Years	256 (52%)	386 (54%)	102 (53%)	744 (53%)
50-64 Years	51 (10%)	139 (19%)	15 (8%)	205 (15%)
65-74 Years	18 (4%)	34 (5%)	10 (5%)	62 (4%)
75+ Years	4 (1%)	9 (1%)	0 (0%)	13 (1%)
N/A	16 (3%)	37 (5%)	12 (6%)	65 (5%)
Total	493 (100%)	717 (100%)	191 (100%)	1401 (100%)

What sex were you assigned at birth?				
city	Female	Male	NA_	Total
Chelsea	335 (68%)	155 (31%)	3 (1%)	493 (100%)
Revere	442 (62%)	258 (36%)	17 (2%)	717 (100%)
Winthrop	114 (60%)	76 (40%)	1 (1%)	191 (100%)
Total	891 (64%)	489 (35%)	21 (1%)	1401 (100%)

What is your current gender identity?							
city	Genderqueer or gender non-conforming	Man	Prefer to self-describe:	Transgender	Woman	NA_	Total
Chelsea	13 (3%)	149 (30%)	2 (0%)	7 (1%)	320 (65%)	2 (0%)	493 (100%)
Revere	11 (2%)	257 (36%)	2 (0%)	3 (0%)	428 (60%)	16 (2%)	717 (100%)
Winthrop	1 (1%)	75 (39%)	0 (0%)	0 (0%)	113 (59%)	2 (1%)	191 (100%)
Total	25 (2%)	481 (34%)	4 (0%)	10 (1%)	861 (61%)	20 (1%)	1401 (100%)

What is your sexual orientation?						
city	Bisexual	Gay or lesbian	Prefer to self-describe:	Straight/heterosexual	NA_	Total
Chelsea	30 (6%)	12 (2%)	5 (1%)	429 (87%)	17 (3%)	493 (100%)
Revere	24 (3%)	12 (2%)	10 (1%)	630 (88%)	41 (6%)	717 (100%)
Winthrop	12 (6%)	1 (1%)	0 (0%)	172 (90%)	6 (3%)	191 (100%)
Total	66 (5%)	25 (2%)	15 (1%)	1231 (88%)	64 (5%)	1401 (100%)

Do you identify as a person with a disability?				
city	No	Yes	NA_	Total
Chelsea	415 (84%)	70 (14%)	8 (2%)	493 (100%)
Revere	622 (87%)	69 (10%)	26 (4%)	717 (100%)

Winthrop	172 (90%)	16 (8%)	3 (2%)	191 (100%)
Total	1209 (86%)	155 (11%)	37 (3%)	1401 (100%)

Which of these groups best represents your race? (Please check all that apply.)

	Chelsea	Revere	Winthrop	Total
American Indian or Alaska Native	37 (7%)	12 (2%)	30 (15%)	79 (5%)
Asian	31 (6%)	33 (5%)	9 (5%)	73 (5%)
Asian American	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Black or African American	30 (6%)	36 (5%)	6 (3%)	72 (5%)
Brazilian	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Hispanic or Latino	278 (54%)	418 (57%)	9 (5%)	705 (49%)
Is it. Racist to ask ??	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Italian	0 (0%)	1 (0%)	4 (2%)	5 (0%)
Italian/Sicilian	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Kids half Asian	0 (0%)	0 (0%)	1 (1%)	1 (0%)
Mixed	0 (0%)	2 (0%)	0 (0%)	2 (0%)
Mixed race	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Mixed Race	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Native Hawaiian or other Pacific Islander	8 (2%)	6 (1%)	1 (1%)	15 (1%)
North Africa	0 (0%)	1 (0%)	0 (0%)	1 (0%)
North African	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Scot,Scott, Irish, English, Spanish, and Cherokee	1 (0%)	0 (0%)	0 (0%)	1 (0%)
Semitic And White	0 (0%)	0 (0%)	1 (1%)	1 (0%)
White	134 (26%)	211 (29%)	135 (69%)	480 (33%)
X	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Total	519 (100%)	728 (100%)	196 (100%)	1443 (100%)

Which of these best represents your ethnicity? (Please check all that apply.)

	Chelsea	Revere	Winthrop	Total
African (specify below)	16 (3%)	13 (2%)	3 (1%)	32 (2%)

African American	18 (3%)	21 (3%)	3 (1%)	42 (3%)
American	136 (25%)	171 (22%)	148 (73%)	455 (30%)
Brazilian	2 (0%)	13 (2%)	0 (0%)	15 (1%)
Cambodian	1 (0%)	13 (2%)	0 (0%)	14 (1%)
Cape Verdean	1 (0%)	3 (0%)	3 (1%)	7 (0%)
Caribbean Islander (specify below)	4 (1%)	6 (1%)	1 (0%)	11 (1%)
Chinese	21 (4%)	12 (2%)	4 (2%)	37 (2%)
Colombian	28 (5%)	129 (17%)	0 (0%)	157 (10%)
Cuban	1 (0%)	2 (0%)	0 (0%)	3 (0%)
Dominican	22 (4%)	6 (1%)	2 (1%)	30 (2%)
European (specify below)	22 (4%)	34 (4%)	5 (2%)	61 (4%)
Filipino	4 (1%)	4 (1%)	1 (0%)	9 (1%)
Guatemalan	37 (7%)	33 (4%)	1 (0%)	71 (5%)
Haitian	5 (1%)	8 (1%)	1 (0%)	14 (1%)
Honduran	48 (9%)	33 (4%)	5 (2%)	86 (6%)
Indian	3 (1%)	7 (1%)	0 (0%)	10 (1%)
Japanese	3 (1%)	3 (0%)	1 (0%)	7 (0%)
Korean	2 (0%)	2 (0%)	4 (2%)	8 (1%)
Laotian	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Mexican, Mexican-American, Chicano	20 (4%)	27 (4%)	4 (2%)	51 (3%)
Middle Eastern (specify below)	3 (1%)	5 (1%)	4 (2%)	12 (1%)
Other (specify below)	10 (2%)	18 (2%)	3 (1%)	31 (2%)
Portuguese	2 (0%)	6 (1%)	2 (1%)	10 (1%)
Puerto Rican	20 (4%)	28 (4%)	2 (1%)	50 (3%)
Russian	1 (0%)	5 (1%)	2 (1%)	8 (1%)
Salvadoran	119 (22%)	159 (21%)	4 (2%)	282 (19%)
Vietnamese	1 (0%)	4 (1%)	0 (0%)	5 (0%)
Total	550 (100%)	766 (100%)	203 (100%)	1519 (100%)

What is the primary language(s) spoken in your home? (Please check all that apply).				
	Chelsea	Revere	Winthrop	Total

Albanian	1 (0%)	2 (0%)	0 (0%)	3 (0%)
Amharic	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Arabic	11 (2%)	16 (2%)	3 (1%)	30 (2%)
Bosnian	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Brazilian Portuguese	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Cambodian	0 (0%)	0 (0%)	1 (0%)	1 (0%)
Cambodian/Khmer	9 (2%)	9 (1%)	1 (0%)	19 (1%)
Cape Verdean Creole	7 (1%)	13 (2%)	3 (1%)	23 (1%)
Chinese (including Mandarin or Cantonese)	25 (4%)	19 (2%)	9 (4%)	53 (3%)
English	216 (38%)	310 (37%)	177 (82%)	703 (44%)
French	3 (1%)	8 (1%)	1 (0%)	12 (1%)
Haitian Creole	1 (0%)	3 (0%)	0 (0%)	4 (0%)
Hindi	6 (1%)	4 (0%)	0 (0%)	10 (1%)
Italian	0 (0%)	0 (0%)	5 (2%)	5 (0%)
Japanese	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Khmer	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Korean	4 (1%)	6 (1%)	5 (2%)	15 (1%)
Krundi	1 (0%)	0 (0%)	0 (0%)	1 (0%)
Mostly Spanish	1 (0%)	0 (0%)	0 (0%)	1 (0%)
Polish	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Portuguese	5 (1%)	17 (2%)	3 (1%)	25 (2%)
Russian	1 (0%)	9 (1%)	1 (0%)	11 (1%)
Rwandese, Luganda	0 (0%)	1 (0%)	0 (0%)	1 (0%)
Spanish	271 (48%)	408 (49%)	6 (3%)	685 (43%)
Vietnamese	2 (0%)	1 (0%)	0 (0%)	3 (0%)
Total	564 (100%)	832 (100%)	215 (100%)	1611 (100%)

What is the highest grade or level of school that you have completed?				
	Chelsea	Revere	Winthrop	Total
Associate's degree, technical/trade school	64 (13%)	119 (17%)	42 (22%)	225 (16%)
College degree (Bachelor's)	91 (18%)	140 (20%)	98 (51%)	329 (23%)

Grade 12 (completed high school or GED)	99 (20%)	160 (22%)	21 (11%)	280 (20%)
Grades 1–8 (less than high school)	92 (19%)	103 (14%)	0 (0%)	195 (14%)
Grades 9–11 (some high school)	69 (14%)	85 (12%)	5 (3%)	159 (11%)
Graduate degree (Master's or Doctorate)	39 (8%)	48 (7%)	22 (12%)	109 (8%)
Never attended school	36 (7%)	49 (7%)	1 (1%)	86 (6%)
N/A	3 (1%)	13 (2%)	2 (1%)	18 (1%)
Total	493 (100%)	717 (100%)	191 (100%)	1401 (100%)

Are you currently:				
	Chelsea	Revere	Winthrop	Total
A stay at home parent	45 (9%)	66 (9%)	2 (1%)	113 (8%)
A student (full or part time)	17 (3%)	17 (2%)	6 (3%)	40 (3%)
Employed full time	219 (42%)	314 (43%)	146 (73%)	679 (47%)
Employed part time or seasonal work	148 (29%)	217 (29%)	19 (10%)	384 (26%)
Out of work for less than 1 year	12 (2%)	9 (1%)	3 (2%)	24 (2%)
Out of work for more than 1 year	16 (3%)	23 (3%)	2 (1%)	41 (3%)
Retired	13 (3%)	26 (4%)	9 (5%)	48 (3%)
Self-employed (full or part time)	25 (5%)	35 (5%)	8 (4%)	68 (5%)
Unable to work for health reasons	24 (5%)	29 (4%)	4 (2%)	57 (4%)
Total	519 (100%)	736 (100%)	199 (100%)	1454 (100%)

Did you experience a change in employment due to the COVID-19 pandemic?				
	Chelsea	Revere	Winthrop	Total
Job loss (permanent or temporary)	162 (31%)	200 (29%)	13 (7%)	375 (27%)
Nature of work changed (increased hours, change in role, new job, or working from home)	80 (15%)	100 (15%)	37 (20%)	217 (16%)
No change in employment	82 (16%)	138 (20%)	45 (24%)	265 (19%)
Reduced hours	152 (29%)	195 (29%)	80 (43%)	427 (31%)
Took leave of absence (paid or unpaid)	50 (10%)	51 (7%)	13 (7%)	114 (8%)
Total	526 (100%)	684 (100%)	188 (100%)	1398 (100%)

How long have you lived in the United States?

city	1 to 3 years	4 to 6 years	I have always lived in the United States	Less than one year	More than 6 years, but not my whole life	NA_	Total
Chelsea	41 (8%)	80 (16%)	135 (27%)	9 (2%)	223 (45%)	5 (1%)	493 (100%)
Revere	25 (3%)	80 (11%)	221 (31%)	4 (1%)	375 (52%)	12 (2%)	717 (100%)
Winthrop	5 (3%)	10 (5%)	131 (69%)	1 (1%)	38 (20%)	6 (3%)	191 (100%)
Total	71 (5%)	170 (12%)	487 (35%)	14 (1%)	636 (45%)	23 (2%)	1401 (100%)

Have you served on active duty in the U.S. Armed Forces, Reserves, or National Guard?

city	Never served in the military	On active duty in the past, but not now (includes retirement)	On active duty now (in any branch)	NA_	Total
Chelsea	437 (89%)	27 (5%)	16 (3%)	13 (3%)	493 (100%)
Revere	641 (89%)	27 (4%)	10 (1%)	39 (5%)	717 (100%)
Winthrop	133 (70%)	11 (6%)	1 (1%)	46 (24%)	191 (100%)
Total	1211 (86%)	65 (5%)	27 (2%)	98 (7%)	1401 (100%)

How would you describe your current housing situation?

	Chelsea	Revere	Winthrop	Total
I am experiencing homelessness or staying in a shelter	7 (1%)	6 (1%)	0 (0%)	13 (1%)
I am staying with another household	34 (7%)	45 (6%)	4 (2%)	83 (6%)
I own my home	152 (31%)	215 (30%)	137 (72%)	504 (36%)

I rent my home	282 (57%)	424 (59%)	48 (25%)	754 (54%)
Other (please specify)	13 (3%)	4 (1%)	1 (1%)	18 (1%)
N/A	5 (1%)	23 (3%)	1 (1%)	29 (2%)
Total	493 (100%)	717 (100%)	191 (100%)	1401 (100%)

If you rent or own your home, who do you live with?			
response	Chelsea	Revere	Winthrop
I live alone	54 (12.9%)	55 (9.1%)	11 (6%)
My children or dependents	250 (60%)	368 (60.8%)	120 (65.2%)
My parents	50 (12%)	61 (10.1%)	29 (15.8%)
Other family or relatives	25 (6%)	65 (10.7%)	8 (4.3%)
Roommates or people I am not related to	34 (8.2%)	18 (3%)	9 (4.9%)
Spouse or domestic partner	215 (51.6%)	436 (72.1%)	143 (77.7%)
Total	417	605	184

Are you the parent or caregiver of a child under the age of 18?				
city	No	Yes	NA_	Total
Chelsea	206 (42%)	283 (57%)	4 (1%)	493 (100%)
Revere	328 (46%)	377 (53%)	12 (2%)	717 (100%)
Winthrop	63 (33%)	87 (46%)	41 (21%)	191 (100%)
Total	597 (43%)	747 (53%)	57 (4%)	1401 (100%)

Do you provide regular unpaid assistance or care to a family member or other dependent because of a health condition, disability, or elderly age?				
city	No	Yes	NA_	Total
Chelsea	349 (71%)	137 (28%)	7 (1%)	493 (100%)
Revere	573 (80%)	125 (17%)	19 (3%)	717 (100%)
Winthrop	133 (70%)	39 (20%)	19 (10%)	191 (100%)
Total	1055 (75%)	301 (21%)	45 (3%)	1401 (100%)

If yes, how old are the children you care for? (Please check all that apply.)			
	Chelsea	Revere	Winthrop
0-3 years	62 (23.4%)	77 (22.1%)	15 (20.5%)
11-14 years	66 (24.9%)	95 (27.2%)	22 (30.1%)
15-17 years	39 (14.7%)	64 (18.3%)	2 (2.7%)
4-5 years	83 (31.3%)	91 (26.1%)	18 (24.7%)
6-10 years	111 (41.9%)	152 (43.6%)	23 (31.5%)
Total	265	349	73

How would you describe your health in general?							
city	Excellent	Very Good	Good	Fair	Poor	NA_	Total
Chelsea	95 (19%)	124 (25%)	150 (30%)	103 (21%)	18 (4%)	3 (1%)	493 (100%)
Revere	88 (12%)	136 (19%)	319 (44%)	138 (19%)	24 (3%)	12 (2%)	717 (100%)
Winthrop	42 (22%)	51 (27%)	85 (45%)	10 (5%)	1 (1%)	2 (1%)	191 (100%)
Total	225 (16%)	311 (22%)	554 (40%)	251 (18%)	43 (3%)	17 (1%)	1401 (100%)

What kind of health insurance or health care coverage do you have?				
	Chelsea	Revere	Winthrop	Total
Free Care or Health Safety Net	58 (12%)	53 (7%)	28 (15%)	139 (10%)
Health Connector Plan that you purchased yourself	54 (11%)	83 (12%)	25 (13%)	162 (12%)
Insurance through an employer or union	86 (17%)	124 (17%)	78 (41%)	288 (21%)
MassHealth or ConnectorCare	210 (43%)	343 (48%)	18 (9%)	571 (41%)
Medicare	55 (11%)	64 (9%)	22 (12%)	141 (10%)
No health care coverage / Uninsured	11 (2%)	16 (2%)	1 (1%)	28 (2%)
Other (please specify)	12 (2%)	11 (2%)	0 (0%)	23 (2%)
Student health plan	2 (0%)	2 (0%)	3 (2%)	7 (0%)

Veterans Affairs, Military Health, or TRICARE	2 (0%)	3 (0%)	0 (0%)	5 (0%)
N/A	3 (1%)	18 (3%)	16 (8%)	37 (3%)
Total	493 (100%)	717 (100%)	191 (100%)	1401 (100%)

Appendix C:
Resource Inventory

Beth Israel Deaconess Medical Center Community Resource List					
Community Benefits Service Area includes: Brookline, Burlington, Chestnut Hill, Lexington, Peabody, and Needham, and the City of Boston Neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, and Roxbury/Mission Hill					
Health Issue	**Organization**	**Brief Description**	**Address**	**Phone**	**Website**
Statewide Resources	Department of Mental Health-Handhold program	Provides tips, tools, and resources to help families navigate children's mental health journey.			www.handholdma.org
	Executive Office of Elder Affairs	Provides access to the resources for older adults to live healthy in every community in the Commonwealth.	1 Ashburton Place 5th Floor Boston	617.727.7750	www.mass.gov/orgs/executive-office-of-elder-affairs
	Mass 211	Available 24 hours a day, 7 days a week, Mass 211 is an easy way to find or give help in your community.		211 or 877.211.6277	www.mass211.org
	Massachusetts Elder Abuse Hotline	Hotline is available 24 hours a day or by phone. Older adult abuse includes: physical, sexual, and emotional abuse, caretaker neglect, financial exploitation and self-neglect. Elder Protective Services can only investigate cases of abuse where the person is age 60 and over and lives in the community.	1 Ashburton Place 5th Floor Boston	800.922.2275	www.mass.gov/orgs/executive-office-of-elder-affairs
	Women, Infants and Children (WIC) Nutrition Program	Provides free nutrition, health education and other services to families who qualify.		800.942.1007	www.mass.gov/orgs/women-infants-children-nutrition-program
	MassOptions	Provides connection to services for older adults and persons with disabilities.		800.243.4636	www.massoptions.org
	Massachusetts Substance Use Helpline	24/7 Free and confidential public resource for finding substance use treatment and recovery services.		800.327.5050	www.helplinema.org
	National Suicide Prevention Lifeline	Provides 24/7, free and confidential support.		800.273.8255	www.suicidepreventionlifeline.org
	Network of Care Massachusetts	Provides a searchable directory of over 5,000 Behavioral Health service providers in Massachusetts.			www.massachusetts.networkofcare.org
	Project Bread Foodsource Hotline	Provides information about food resources in the community and assistance with SNAP applications by phone.		1.800.645.8333	www.projectbread.org/get-help
	SafeLink	Massachusetts' statewide 24/7 toll-free domestic violence hotline and a resource for anyone affected by domestic or dating violence.		877.785.2020	www.casamyrna.org/get-support/safelink

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Health Issue	**Organization**	**Brief Description**	**Address**	**Phone**	**Website**
Statewide Resources	SAMHSA's National Helpline	Provides a free, confidential, 24/7, 365-day-a-year treatment referral and information service (in English and Spanish) for individuals and families in need of mental health resources and/or information for those with substance use disorders.		800.662.HELP (4357)	www.samhsa.gov/find-help/national-helpline
	Supplemental Nutritional Assistance Program (SNAP)	Provides nutrition benefits to individuals and families to help subsidize food costs.		877.382.2363	www.mass.gov/snap-benefits-formerly-food-stamps
	Veteran Crisis Hotline	Free, every day, 24/7 confidential support for Veterans and their families who may be experiencing challenges.		800.273.8255	www.veteranscrisisline.net
Domestic Violence	BIDMC Center for Violence Prevention	Provides outreach and treatment interventions to respond to victims of interpersonal, sexual, community violence, and homicide bereavement.	330 Brookline Ave Boston	617.667.8141	www.bidmc.org/centers-and-departments/social-work/center-for-violence-prevention-and-recovery
	Boston Area Rape Crisis Center	Provides free, confidential support and services to survivors of sexual violence.	989 Commonwealth Ave Boston	617.492.8306 24/7 Hotline: 800.841.8371	www.barcc.org
	Casa Myrna	Provides domestic violence awareness efforts, shelter and supportive services to survivors.	451 Blue Hill Ave Boston	617.521.0100	www.casamyrna.org
	Cory Johnson Program	Offers a peer-centered approach to addressing post-traumatic stress in urban neighborhoods.	328 Warren St Roxbury	617.445.6262	www.rpcsocialimpactctr.org/about
	The Elizabeth Stone House	Provides support to survivors of domestic violence in four areas of intervention: safety and shelter; advocacy; education and prevention; community engagement.	1 Westminster Ave Roxbury	Mainline: 617.427.9801 Intake line: 781.400.0770	www.stonehouseinc.org
	The Network/La Red	Survivor-led, social justice organization that works to end partner abuse in lesbian, gay, bisexual, transgender, SM, polyamorous, and queer communities.	PO Box 6011 Boston	Office: 617.695.0877 Hotline Voice: 617.742.4911 Hotline Toll-Free: 800.832.1901	www.tnlr.org/en

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Health Issue	**Organization**	**Brief Description**	**Address**	**Phone**	**Website**
Domestic Violence	REACH Beyond Domestic Violence	Provides support to survivors of domestic violence in four areas of intervention: safety and shelter; advocacy; education and prevention; community engagement.	PO Box 540024 Waltham	781.891.0724 Hotline: 800.899.4000	www.reachma.org
Food Assistance	ABCD Food Pantry	Provides food assistance to residents of Boston.	178 Tremont St Boston	617.348.6000	www.bostonabcd.org/service/food-pantries/
	Community Servings	Provides meals to chronically and critically ill individuals and their families.	179 Amory St Jamaica Plain	617.522.7777	www.servings.org
	Daily Table	Provides food assistance to residents of Greater Boston.	2201 Washington St Roxbury	617.516.8174	www.dailytable.org
	Dorchester Community Food Co-Op	An initiative to build a community and worker-owned grocery store that provides healthy food accessibility and advances economic opportunity through neighborhood engagement.	195 Bowdoin St Dorchester	Opening 2022	www.dorchesterfoodcoop.com/
	Fair Foods	Provides food assistance to residents of Greater Boston for $2.	PO Box 220168 Dorchester	617.288.6185	www.fairfoods.org/
	Fenway Cares	Provides food assistance to residents of Fenway/Kenmore community residents.	1282 Boylston St Boston	857.246.9053	www.fenwaycommunitycenter.org/fenwaycares/
	Fresh Truck	Provides food assistance to residents of Greater Boston via mobile markets.	69 Shirley St Boston	617.297.7685	www.aboutfresh.org
	Greater Boston Food Bank	Provides healthy food and resources to agencies and direct distribution programs across Eastern Massachusetts.	70 South Bay Ave Boston	617.427.5200	www.gbfb.org
	Mayor's Office of Food Access	Provides food assistance to residents of Boston.	1 City Hall Sq. Room 806 Boston	617.635.3717	www.boston.gov/departments/food-access
Housing Support	Allston Brighton CDC	Leads initiatives that create and preserve affordable homes, foster community leadership, and provide first-time homebuyers with tools and resources.	18R Shepard St Ste 199, Brighton	617.787.3874	www.allstonbrightoncdc.org/

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Health Issue	**Organization**	**Brief Description**	**Address**	**Phone**	**Website**
Housing Support	Asian CDC	Works in underserved and immigrant Asian American communities to create and preserve affordable, sustainable, and healthy neighborhoods.	38 Oak St Boston	617.482.2380	www.asiancdc.org/
	Boston Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals.	52 Chauncy St Boston	617.988.4000	www.bostonhousing.org
	Boston Tenant Coalition	Promotes affordable housing in Boston, organized to defend and expand the rights of tenants, and to push city, state and federal government, as well as private industry to address the needs of low-resources tenants.	11 Beacon St Ste 510 Boston	617.423.8609	www.bostontenant.org
	Bridge Over Troubled Waters	Provides services for youth without housing, runaway and at risk youth.	47 West St Boston	617.423.9575	www.bridgeotw.org
	Chelsea Housing Authority	Provides affordable, subsidized rental housing for low-resource individuals and families, older adults and persons with disabilities.	54 Locke St Chelsea	617.409.5310	www.chelseaha.com
	City of Boston Emergency Shelter Commission	Coordinate the City's efforts to prevent and end homelessness and food insecurity through proactive planning, policy analysis, program development and advocacy with our city, state, federal and community partner agencies.	1010 Massachusetts Ave 6th Floor Boston	617.534.5395	www.bphc.org/whatwedo/homelessness/emergency-shelter-commission/Pages/Emergency-Shelter-Commission.aspx
	Empath	Disrupts poverty through direct services, advocacy, research, and a global learning network. Helps individuals move out of poverty and provide other institutions with the tools to systematically do the same.	10 Perthshire Rd Brighton	857.559.2100	www.empathways.org
	ESAC Boston	Provides innovative programs in home ownership, education, and community service focusing on children and older adults.	434 Jamaicaway Jamaica Plain	617.524.2555	www.esacboston.org
	Family Aid Boston	Empowers parents and caregivers facing homelessness to secure and sustain housing and build strong foundations for their children’s futures.	3815 Washington St Boston	617.542.7286	www.familyaidboston.org

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Health Issue	**Organization**	**Brief Description**	**Address**	**Phone**	**Website**
Housing Support	Fenway CDC	Provides affordable, subsidized rental housing for low-resource individuals and families.	70 Burbank St Boston	617.267.4637	www.fenwaycdc.org/
	Greater Boston Legal Services	Provides free legal assistance to low-resource families to assist them in securing basic necessities.	197 Friend St Boston	617.371.1234	www.gbls.org
	Homestart	Provides information and resources for low and moderate resource individuals.	105 Chauncy St Ste 502 Boston	617.542.0338	www.homestart.org
	Hospitality Homes	Provides short-term housing for families/friends of patients receiving medical care in the Boston area.	PO Box 15265 Boston	888.595.4678	www.hosp.org
	Inquilinos Boricuas Accion (IBA)	Provides affordable, subsidized rental housing, education, and arts programs.	405 Shawmut Ave Boston	617.927.1707	www.ibaboston.org
	Mayor's Office of Housing Stability	Helps residents find and maintain stable, safe, and affordable housing.	43 Hawkins St Boston	617.635.4200	www.boston.gov/departments/housing/office-housing-stability
	MetroHousing Boston	Provides information and resources for low and moderate resource families and individuals.	1411 Tremont St Boston	617.859.0400	www.MetroHousingBoston.org
	Nuestra Comunidad Development Corporation	Works to revitalize communities and assure that all families have affordable homes by transforming vacant and abandoned lots and buildings into housing.	56 Warren St Ste 200 Roxbury	617.427.3599	www.nuestracdc.org/
	Pine Street Inn	Provides temporary shelter to unhoused individuals.	444 Harrison Ave Boston	617.892.9100	www.pinestreetinn.org
	Rosie's Place	A multi-service community center that offers women emergency shelter and meals, a food pantry, ESOL classes, legal assistance, wellness care, one-on-one support, housing and job search services, and community outreach.	889 Harrison Ave Boston	617.442.9322	www.rosiesplace.org
	Urban Edge	Provides affordable, subsidized rental housing.	1542 Columbus Ave Roxbury	617.989.9300	www.urbanedge.org
	Y2Y	Employs a youth-to-youth model to provide a safe and environment for young adults 18-24 experiencing homelessness.	955 Massachusetts Ave #424 Cambridge	617.864.0795	www.y2ynetwork.org/

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Health Issue	**Organization**	**Brief Description**	**Address**	**Phone**	**Website**
Mental Health and Substance Use	Beth Israel Lahey Health (BILH) Behavioral Services	Provides high-quality mental health and addiction treatment for children and adults ranging from inpatient to community-based services.		978.968.1700	www.nebhealth.org
	Boston Treatment Center	Provides inpatient detoxification and treatment services to both men and women from alcohol, opiates and benzodiazepines.	784 Massachusetts Ave Boston	617.247.1001	www.nebhealth.org
	Column Health	Provides outpatient mental health and addiction treatment.	71 Washington St Brighton	844.910.2034	www.columnhealth.com
	The Family Van	Educates, counsels and assists community members in strengthening and protecting their bodies, minds and communities.		617.442.3200	www.familyvan.org
	Fathers Uplift	Provides mental health counseling, coaching, advocacy, and resource support to assist fathers with overcoming barriers that prevent them from remaining engaged in their children's lives.	12 Southern Ave Dorchester	617.708.0870	www.fathersuplift.org
	Mayors Health Line	Works to ensure Boston residents' ability to access services and programs that promote health and wellness. The MHL staff is available to help residents with a variety of services including, answering questions about health insurance eligibility, enrolling in health insurance, finding primary care providers, finding social services, locating free clinics.	1010 Massachusetts Ave 2nd Floor Boston	617.534.5050	www.bphc.org/aboutus/mayors-health-line/Pages/mhl.aspx
	North Suffolk Mental Health Association	Provides a wide variety of behavioral health treatment and rehabilitation services.	301 Broadway Chelsea	617.889.4860	www.northsuffolk.org
Senior Services	Agestrong Commission	Provides services for older adults in Boston including fitness, education, social services, and recreation.	1 City Hall Sq. Room 271 Boston	617.635.4366	www.boston.gov/departments/age-strong-commission
	BCYF Grove Hall Senior Center	Provides access to resources and programs for older adults in Boston.	51 Geneva Ave Boston	617.635.1484	www.boston.gov/departments/boston-centers-youth-families/bcyf-grove-hall-senior-center

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Health Issue	**Organization**	**Brief Description**	**Address**	**Phone**	**Website**
Senior Services	Boston Elder INFO	Provides resources for older adults and person with disabilities who are residents of Boston.	89 South St Boston	617.292.4762	www.elderinfo.org
	Central Boston Elder Services	Provide supportive services for older adults and persons with disabilities.	2315 Washington St Boston	617.277.7416	www.centralboston.org
	Chelsea Senior Center	Provides services for older adults in Chelsea including fitness, education, social services, and recreation.	10 Riley Way Chelsea	617.466.4370	www.chelseama.gov/elder-services
	ETHOS	Provides programs and services which are available and accessible to meet the diverse needs and changing lifestyles of older adults.	555 Amory St Jamaica Plain	617.522.6700	www.ethocare.org
	FriendshipWorks	Works to reduce social isolation in older adults residing in Boston.	105 Chauncy St 8th floor Boston	617.482.1510	www.fw4elders.org
	Greater Boston Chinese Golden Age Center	Offers a network of programs that serve the needs of the older adult Chinese population.	75 Kneeland St Ste 204 Boston	617.357.0226	www.gbcgac.org
	Lexington Senior Center	Provides services for older adults in Lexington including fitness, education, social services, recreation, and transportation.	39 Marrett Rd Lexington	781.698.4840	www.lexingtonma.gov/human-services/senior-services
	Veronica B. Smith Senior Center	Provides services for older adults in Boston including fitness, education, social services, recreation, and transportation.	20 Chestnut Hill Ave Boston	617.635.6120	www.boston.gov/departments/age-strong-commission/veronica-b-smith-senior-center
Transportation	Boston Cyclist Union	Campaign for better bike infrastructure and safer streets throughout Metro Boston. Engages with policymakers and elected officials, organize residents, and mobilize membership to influence projects.	1419 Tremont St Boston	617.516.8877	www.bostoncyclistsunion.org/
	MBTA	Provides transportation throughout Boston and surrounding communities.			www.mbta.com
	TransitMatters	Dedicated to improving transit in and around Boston by offering new perspectives, uniting transit advocates, and informing the public.	62 Summer St Boston		www.transitmatters.org

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Health Issue	**Organization**	**Brief Description**	**Address**	**Phone**	**Website**
Transportation	WalkBoston	Helps people evaluate the walking environment, develop plans to improve walking conditions, and encourage walking activities.	45 School St Boston	617.367.9255	www.walkboston.org
Additional Resources	African Community Economic Development of New England (ACEDONE)	Helps African refugees and immigrants in Boston develop a self-sufficient and vital community by providing our youth with the education and life experience to thrive socially, professionally, and economically.	48 John Eliot Sq. Roxbury 89 South St Ste 2A Boston	617.708.0754	www.acedone.org
	BAGLY (Boston Alliance of Gay, Lesbian, Bisexual and Transgender Youth)	Provides community-based leadership development, health promotion, and social support programs for Massachusetts LGBTQ youth communities.	28 Court Sq. Boston	617.227.4313	www.bagly.org
	Boston Chinatown Neighborhood Center	Provides a broad range of innovative programs and services centered around education, workforce development, family support, and arts and culture.	38 Ash St Boston	617.635.5129	www.bcnc.net
	Boston Public Health Commission	Provides a wide-range of services in child, adolescent and family health; community health initiatives; homeless services; infectious disease; recovery services; and emergency medical services.	1010 Massachusetts Ave 6th Floor Boston	617.534.5395	www.bphc.org
	English for New Bostonians	Provides English language learning programs to non-English speaking residents.	105 Chauncy St 4th Floor Boston	617.982.6860	www.englishfornewbostonians.org
	Jewish Vocational Services	Provides adult education and workforce development services, serving a diverse clientele and helping people secure financial independence through educational and employment services.	75 Federal St 3rd Floor Boston	617.399.3131	www.jvs-boston.org
	Louis D Brown Peace Institute	Serves as a center of healing, teaching, and learning for families and communities impacted by murder, trauma, grief, and loss.	15 Christopher St Dorchester	617.825.1917	www.ldbpeaceinstitute.org

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Health Issue	**Organization**	**Brief Description**	**Address**	**Phone**	**Website**
Additional Resources	The Neighborhood Developers	Promotes economic diversity, opportunity, and quality of life in the communities of Chelsea, Revere, and Everett.	4 Gerrish Ave #2 Chelsea	617.889.1375	www.theneighborhooddevelopers.org
	Oak Square YMCA	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	615 Washington St Brighton	617.782.3535	www.ymcaboston.org
	Sociedad Latina	Provides high-quality, comprehensive, and holistic out-of-school time programming in four key areas that meet the needs and interests of the community: Education, Workforce Development, Civic Engagement, and Arts and Culture.	1530 Tremont St Roxbury	617.442.4299	www.sociedadlatina.org
	United Way of Massachusetts Bay & Merrimack Valley	Work to create positive and lasting change for people through financial opportunity and educational success.	9 Channel Center St Ste 500 Boston	617.627.8000	www.unitedwaymassbay.org
	Wang YMCA of Chinatown	Offers a wide range of youth development programs, healthy living and fitness classes, and social responsibility outreach opportunities.	8 Oak St West Boston	617.426.2237	www.ymcaboston.org
	West End House Boys and Girls Club	Offers programs in Five Core Program Areas: The Arts, Health & Life Skills, Character & Leadership Development, Education & Career Development and Sports, Fitness and Recreation.	105 Allston St Allston	617.787.4044	www.westendhouse.org

Appendix D:

Evaluation of 2020-2022 Implementation Strategy

Beth Israel Deaconess Medical Center (BIDMC)
Evaluation of 2020-2022 Implementation Strategy

Below are highlights of the work that has been accomplished since the last Implementation Strategy. All metrics are based on BIDMC FY20-21 (October 2019 – September 2021) unless otherwise stated. For full reports, please see submissions to the Massachusetts Attorney General Community Benefits office (https://massago.onbaseonline.com/massago/1801CBS/annualreport.aspx).

Populations: Youth and adolescents, older adults, low-resource individuals and families, LGBTQ, racially and ethnically diverse populations/non-English speakers

Priority: Social Determinants of Health

Goal 1: Promote Healthy Neighborhoods by Increasing Healthy Eating, Active Living, and Other Healthy Behaviors, as well as Promoting Other Health-related Programs and Policies		
Objectives	Activities	Progress, Outcomes, and Impact
• Increase the number of children in Community Care Alliance (CCA) clinics who are screened for Body Mass Index (BMI) • Increase the number of children, youth, and adults who are physically active • Develop and update annually a strategic program plan for Bowdoin Street Wellness Center • Increase access to healthy and affordable foods in the community • Improve nutritional quality of the food supply • Decrease the number of individuals and families who suffer from food insecurity • Provide opportunities for neighborhoods to identify and address unique neighborhood needs	• Promote universal screening for BMI along with appropriate counseling for physical activity and nutrition • Support and promote the development of walking and other physical activity groups (e.g., Zumba, tai chi, High Intensity Interval Training (HIIT), yoga, and group fitness classes) in schools, community-based and primary care-based settings (e.g., Bowdoin Street Health Center (BSHC) and Charles River Community Health (CRCH)) • Support and collaborate with Boston Public Health Commission (BPHC) and community-based organizations (e.g., Daily Table, Greater Boston Food Bank, etc.) to promote accessible/affordable healthy food including Rx food prescription, Farmers Markets etc. • Pilot children's fitness series (age 2-5) – play/ exercise with parents and their kids • Support Healthy Champions, a group of teenagers in healthy cooking and education workshops • Provide nutrition education and counseling (e.g., 5-2-1 Counseling recommended by the American Academy of Pediatrics (AAP)) • Support the Fitness in the City Program at BSHC • Select neighborhood collectives to identify and address unique neighborhood needs	**Active Living and Healthy Eating** • Approximately 67% of children seen at affiliated federally qualified health centers (FQHC) were screened for BMI and counseled on nutrition and physical activity • BSHC conducted a 6-week basketball clinic and provided breakfast and lunch to Fitness in the City participants in FY20 • Fitness in the City had 129 participants • BSHC provided 5- 2-1 counseling (Nutrition, healthy eating, and exercise) recommended by the AAP during routine well child visits at BSHC in FY20 • BIDMC provided pedometers/ walking packets to 8 BPS schools in FY20 • BSHC provided 2,925 food boxes to 125 unique families in FY21

Goal 2: Promote Violence Prevention (Safe Neighborhoods and Community Cohesion)		
Objectives	Activities	Progress, Outcomes, and Impact
• Increase access to mental health services at Bowdoin Street Health Center (BSHC) for affected victims • Increase participation in advocate education and support projects • Provide counseling and other medical services to rape victims • Provide grieving support activities • Conduct neighborhood campaigns to engage community and create greater community cohesion • Increase access to care and support to neighborhoods impacted by trauma through the Neighborhood Trauma Team (NTT)	• Support and organize community meetings where residents share their concerns and discuss possible action steps (Village in Progress (VIP) – call to action) • Identify and empower community leaders through outreach activities to build community cohesion • Support programs in BSHC that integrate services provided by behavioral health specialists and monitor, assess, and treat those experiencing trauma from violence • Hold healing services when appropriate for community residents • Participate in community interventions that raise awareness about violence, engage the community, address factors associated with violence and promote a sense of community • Support and promote the implementation of training programs, support groups for advocates and affected community members • Provide overnight stays for domestic violence and/or sexual assault victims without safe shelter • Conduct public policy advocacy for safe shelters and long-term housing support • Empower youth to develop leadership skills, prevent violence and create change in their community through the Youth Leadership Program at BSHC • Respond to all incidents of homicide or violence within catchment area that meet criteria as established by the Boston Public Health Commission (BPHC) (VIP and NTT)	**Neighborhood Trauma Team (NTT)** • NTT responded to 100% (51 total) of incidents and offered outreach to victims and impacted residents within BSHC's catchment area • NTT Clinicians provided approximately 1,278 therapeutic sessions to individuals impacted by violence **Center for Violence Prevention and Recovery (CVPR)** • Center for Violence Prevention and Recovery (CVPR) provided support to 1,314 victims of domestic, sexual, and community violence in the Greater Boston area • CVPR provided services to 82 survivors of sexual assault in the Emergency Department • CVPR provided free overnight stays for 44 victims of domestic violence • CVPR provided training to 58 community sites around sexual assault, interpersonal violence, community violence, secondary traumatic stress, and human trafficking • CVPR provided 150 peace circles to community members **Village in Progress (VIP) Program in Bowdoin/Geneva Neighborhood** • VIP has worked to sustain communities and support residents by building knowledge, building capacity, and building community **Public Safety** • BIDMC Public Safety department installed 15 emergency call boxes stationed throughout its campus in FY21 **Youth Leadership Program at Bowdoin Street Health Center** • Youth Leadership Program graduated 22 youth who developed strong personal leadership skills and learned to contribute to positive community change and violence prevention

Goal 3: Promote Affordable Housing & Home Ownership		
Objectives	Activities	Progress, Outcomes, and Impact
• Increase access to affordable housing • Increase homeownership • Reduce risk of homelessness	• Conduct public policy and advocacy that aims to increase: access to affordable housing, housing stability, and healthy living conditions (including safety) and improve housing quality • Provide access to housing stability services such as legal aid • Provide resources to mitigate financial "cliff effects" • Provide housing opportunities for LGBTQIA+ youth and homeless youth and young adults • Build capacity of residents to advocate and organize against unjust evictions and foreclosures • Support home buying and financial literacy education • Support homeownership programs	**Determination of Need (DoN) Community-based Health Initiative (CHI)** • Through BIDMC's Community-based Health Initiative (CHI), 7 organizations were funded to address housing affordability • Each CHI Grantee created a logic model to outline project activities and goals • CHI Grantees participated in 7 Evaluation Learning Collaboratives to build their evaluation capacity **Overnight Stays** • In FY21, BIDMC Social Work Department provided housing support to 74 patients in need of short- or long-term housing

Goal 4: Support Workforce Development and Creation of Employment Opportunities		
Objectives	Activities	Progress, Outcomes, and Impact
• Increase mentorship, training, and employment opportunities for youth, young adults, and adults residing in BIDMC's Community Benefits Service Area (CBSA) as well as BIDMC employees • Promote workforce development and capacity building	• Organize and support Pipeline Programs to enhance skills and career advancement • Provide opportunities through Employee Career Initiative (ECI) for college-level courses as well as counseling • Offer English to Speakers of Other Languages (ESOL) classes, GED classes, a basic computer skills course, citizenship classes, and a financial literacy class • Provide job and career introductory opportunities for community residents • Provide job and career introductory opportunities for middle and high school students • Implement and expand Train for Change • Implement and expand Learn and Earn Program through Bunker Hill Community College • Provide support for bi-lingual/bi-cultural providers • Provide paid workforce development opportunities for Latinx, English language learners, and immigrant youth	**Determination of Need (DoN) Community-based Health Initiative (CHI)** • Through BIDMC's Community-based Health Initiative (CHI), 6 organizations were funded to address jobs & financial security • Each CHI Grantee created a logic model to outline project activities and goals • CHI Grantees participated in 7 Evaluation Learning Collaboratives to build their evaluation capacity **Education and Workforce Development** • BIDMC sent job and program listing to 16 community partners in FY20 • BIDMC had 43 participants in pipeline programs including the Pharmacy Tech program with Jewish Vocational Services (JVS) in FY20 • Over 200 job seekers were referred to BIDMC and 40 referrals from community partners were hired in FY21 • BIDMC hired 32 young people for paid, virtual, summer jobs in FY21

Goal 5: Promote Environmental Sustainability		
Objectives	Activities	Progress, Outcomes, and Impact
• Create a healthy future for BIDMC's patients, their families, and staff by conserving natural resources, reducing BIDMC's carbon footprint, and fostering a culture of sustainability.	• Promote recycling, composting, and other programs to divert waste from incineration. • Increase BIDMC's spend on healthy beverages and local and sustainable food. • Reduce consumption of water, energy, and greenhouse gases.	**Environmental Sustainability** • BIDMC's Sustainability Department expanded waste diversion programs to improve solid waste diversion from incineration • BIDMC decreased greenhouse gas emissions related to anesthetic gases through the removal of desflurane from BIDMC's inventory and a focus on reducing sevoflurane usage • Food Services achieved approximately 16% sustainable and local food & beverage spend • BIDMC developed a Zero Waste Strategic Action Plan through a yearlong cross-departmental planning effort

Priority: Chronic / Complex Conditions and their Risk Factors

Goal 1: Improve Chronic Disease Management		
Objectives	Activities	Progress, Outcomes, and Impact
• Increase the number of adults who receive education and counseling regarding risk factors, healthy behaviors to increase chronic disease health literacy • Increase the number of adults screened for diabetes, hypertension, HIV/AIDS, and asthma • Increase the number of adults with diabetes, hypertension, HIV/AIDS, and persistent asthma who receive evidence-based counseling/ coaching and treatment • Increase the number of adults with diabetes, hypertension, HIV/AIDS, and persistent asthma whose conditions are monitored and controlled	• Support programs in Community Care Alliance (CCA) clinics including Live and Learn Diabetes at Charles River Community Health (CRCH) that educate and screen patients for diabetes, hypertension, and persistent asthma • Provide evidence-based counseling/coaching and treatment, as well as appropriate referrals for specialty care services for those who screen positive for diabetes, hypertension, HIV/AIDS, and asthma • Provide screening, education/counseling, and treatment services HIV/AIDS and HIV/HCV co-infection • Support groups for men and women living with HIV/AIDS • Support primary care provider education at CRCH in the area of diabetes management	**Live and Learn Diabetes** • CRCH Medical Assistants (MA) proactively reached out to 68.8% of patients in need of care by using a diabetes registry and documenting A1C checks • 35.5% of CRCH patients ages 18-75 with a diagnosis of diabetes had an HBA1c>9% or no test recorded • 58.2% of CRCH patients 18-85 years of age with hypertension had hypertension controlled (<140/90) • 118 patients participated in the CRCH disease management program Live and Learn Diabetes **Community Care Alliance (CCA) Federally Qualified Health Centers (FQHC)** • 76.5% of adults with diabetes had HbA1C < 9 • 61% of patients with hypertension had blood pressure < 140/90 • The CCA Federally Qualified Health Centers (FQHC) collectively served 10,496 diabetic patients (of which 18% were Hispanic/Latino and 10% were Black/African American); 22,174 patients with hypertension (of which 13.5% were Hispanic/Latino and 9.5% were Black/African American); and 6,295 patients with persistent asthma **Bowdoin Street Health Center (BSHC) Community Health Workers** • Community Health Workers (CHWs) provided supportive intervention to 438 patients in FY21 • CHWs responded to 85 on-call requests for intervention in FY21 • CHWs carried an average case load of at least 74 patients and provided ongoing support and intervention in FY21 **HIV** • 8% of HIV+ patients were screened for Hepatitis C (HCV) at The Dimock Center • An infectious disease physician had 110 visits with 220 patients at The Dimock Center • Six HIV/HCV co-infected patients began HCV treatment

Goal 2: Reduce Cancer Disparities (access to screening and treatment)		
Objectives	Activities	Progress, Outcomes, and Impact
• Increase the number of low income and racially/ethnically diverse adults educated and screened for cancer • Increase the number of adults who screen positive for cancer who are referred for education, counseling and treatment • Increase the number of adults who screen positive for cancer who are linked to a cancer navigator • Increase the number of adults who participate in cancer support groups	• Support access to cancer screening and treatment for low income, uninsured adults (breast, prostate, colon, and lung, cancers), including mammograms, colorectal screening, and CT scans. • Support and promote the city-wide cancer navigators program • Link patients screened positive for cancer to Cancer Patient Navigators • Support the implementation of cancer support groups • Support survivor self-portrait and testimonies activities to reduce stigma in communities (Faces of Faith annual exhibit)	**Reducing Disproportionate Burden of Cancer in Diverse Communities** • 845 patients received mammograms at Fenway Health and 5,483 patients received mammograms at South Cove Community Health Center • BIDMC's Cancer Patient Navigators worked with 838 unique patients and totaled 3,593 encounters • BIDMC hosted 7 different types of cancer support groups • 3,468 low-income individuals received a mammogram at BIDMC • 2,259 low-income individuals received a colon cancer screening at BIDMC • 1,684 BIDMC patients were screened for lung cancer **Research Disparities** • Nurse Navigators enrolled 104 BIDMC patients in Translating Research into Practice, an evidence-based patient navigation intervention aimed at addressing breast cancer care disparities

Goal 3: Support Older Adults to Age in Place		
Objectives	Activities	Progress, Outcomes, and Impact
• Reduce inappropriate readmissions for older adults • Reduce elderly falls • Reduce social isolation	• Increase strength and reduce the risk of falls • Offer health and wellness programming – Bowdoin Street Health Center (BSHC) walking group, Tai Chi, cooking classes • Work with elder buildings to support elder resident groups by providing resources and addressing issues for residents 55+	**Determination of Need (DoN) Community-based Health Initiative (CHI)** • Funded a Community-based Health Initiative (CHI) Grantee that is specifically focused on older adults

Priority: Access to Care

Goal 1: Increase Access to Quality Medical Services, Including Primary Care, OB/GYN, and Specialty Care, as well as Urgent, Emergent, and Trauma Care		
Objectives	Activities	Progress, Outcomes, and Impact
• Increase access to primary medical care services, including OB/GYN services, at BIDMC's Community Care Alliance (CCA) clinic sites and BIDMC's Chelsea Service Site, as well as at its Affiliated Provider Group (APG) and Health Care Associates (HCA) practices • Increase the number of patients receiving specialty care medical services • Increase the number of uninsured or underinsured patients receiving needed medications • Increase access to appropriate, timely urgent, emergent, and trauma care services • Increase the number of residents who are screened and enrolled for health insurance • Increase patient satisfaction • Continue to support for Health Safety Net (HSN) Trust Fund • Advocate for policies supporting public health, mental health and substance abuse and anti-poverty programs	• Support primary medical care services, including OB/GYN services at BIDMC's CCA clinic sites and BIDMC's Chelsea service site, as well as at BIDMC's APG and HCA practices • Support resident rotations into CCA clinic sites • Facilitate referrals to specialty care through Care Connection's Inpatient Discharge Follow Up program • Provide free pharmacy medications to eligible, low income patients • Support the provision of appropriate, timely urgent care services at BIDMC urgent care locations in Chelsea, Chestnut Hill, and the Bowdoin/Geneva neighborhood of Boston, as well as at some of BIDMC's APG practices • Support Med-Flight and coordinated Emergency Medical Services (EMS) in Boston • Support the Commonwealth's HSN • Support activities of the Boston Healthy Start Initiative (BHSI), administered at Bowdoin Street Health Center (BSHC), including case management, nutrition counseling, prenatal education, and parenting support • Support the van (Transportation) with Kit Clark for Seniors • Support clinical operations at CCA clinics • Conduct "Mystery Shopping" to address quality improvement • Support care integration through information sharing, including participation in Mass HIWay and Health Information Exchange • Integrate social justice topics into resident curriculum • Support institutional and community emergency preparedness	**Community-Based Primary and Specialty Care** • 245,917 patients received primary care, OB/GYN, and specialty care at affiliated Community Health Centers (CHCs) • 57 BIDMC specialists practiced at CCA health centers **Community Care Alliance (CCA)** • The Mystery Shopping team shopped BSHC four times each month, totaling 48 shops in FY21 **Trauma, Emergency Management and Public Health Surveillance** • BIDMC collaborates with city, state and federal emergency management programs to ensure preparedness of medical center and CHCs for untoward emergencies. **Care Connection** • The Care Connection call center made 1,859 appointments/referrals to/or from CHCs • In the Doc-to-Doc group, the Care Connection Department processed 4,559 calls • In the Find a Doc group, the BIDMC Care Connection Department processed 23,370 calls **Geographically Isolated Communities** • BIDMC continues ongoing support for Med-Flight **Care for Uninsured and Underinsured in Underserved Communities** • Staff screened 161,593 patients for eligibility and enrolled 24,221 patients into entitlement programs in FY21. Of these patients, 16,942 were enrolled in MassHealth. 7,279 uninsured patients utilized HSN • 64,526 prescriptions were filled for indigent patients • 5,481 ride share/taxi rides, 8 chair cars, 8 ambulances were provided to patients by BIDMC

		Boston Healthy Start Initiative (BHSI) • BHSI Family Partners served 49 prenatal mothers, 56 pregnant clients, 41 postnatal mothers, 62 interconception/parenting clients, and 50 children

Goal 2: Increase Access to Quality Oral Health Services		
Objectives	Activities	Progress, Outcomes, and Impact
• Maintain and increase the number of patients receiving primary dental care services at Federally Qualified Health Centers (FQHC) Community Care Alliance (CCA) clinics	• Support clinical operations at FQHC CCA clinics • Support Health Safety Net (HSN)	• 42,362 dental patients were seen at FQHC CCA health centers • There were 116,195 unique dental visits at FQHC CCA health centers

Goal 3: Promote Equitable Care and Support for Those Who Face Cultural and Linguistic Barriers		
Objectives	Activities	Progress, Outcomes, and Impact
• Maintain or increase the number of non-English speaking patients or residents served by the interpreter services program • Educate staff/clinicians in health equity principles • Promote health equity, health literacy, cultural humility across Community Care Alliance (CCA) clinics	• Increase understanding of cultural impacts on health care delivery, health status and health outcomes • Make available tools and resources to facilitate cross-cultural communication • Increase access to interpreter services	**Culturally and Linguistically Responsive Care** • There were 493,753 interpreter services interactions (in-person, telephone, video and American Sign Language (ASL)) **Evidence-Based Strategies and Research** • Researchers/clinicians engaged in health disparities research efforts through 81 research studies

Goal 4: Promote Greater Health Equity and Reduce Disparities in Access for LGBT Populations		
Objectives	Activities	Progress, Outcomes, and Impact
• Reduce disparities • Promote health equity	• Work to implement Sexual Orientation and Gender Identity (SOGI) data collection appropriate policies and procedures • Collaborate with Fenway Health on Joint Residency Program • Support LGBTQ Pride celebration • Support efforts to achieve Health Care Quality Index recognition (e.g., signage and patient self-identification of sexual orientation)	• Implemented training for BIDMC staff on SOGI data collection • 10,121 BIDMC staff completed the SOGI training • Implemented SOGI capture in WebOMR and patient-site • 34,969 Federally Qualified Health Centers (FQHC) Community Care Alliance (CCA) patients identified as a sexual orientation other than straight • 5,766 FQHC CCA patients identified as transgender **Determination of Need (DoN) Community-based Health Initiative (CHI)** • Funded a Community-based Health Initiative (CHI) Grantee that is specifically focused on the LGBTQIA+ community

Priority: Behavioral Health (Mental Health and Substance Use)

Goal 1: Increase Access to Quality Mental Health Care and Substance Abuse Services		
Objectives	Activities	Progress, Outcomes, and Impact
• Increase patient awareness and knowledge of Behavioral Health Services • Increase the number of patients receiving integrated mental health and substance use services at BIDMC's Community Care Alliance (CCA) clinic sites and BIDMC's Chelsea service site, as well as at BIDMC's Affiliated Provider Group (APG) and Health Care Associates (HCA) practices • Increase access to behavioral health inpatient services at BIDMC inpatient locations • Advocate for health policy that promotes primary care and behavioral health integration • Reduce stigma around behavioral health • Increase capacity of local organizations to provide culturally-informed behavioral health care	• Support primary care medical and behavioral health integration at BIDMC's CCA clinic sites and BIDMC's Chelsea service site, as well as at BIDMC's APG and HCA practices • Continue to provide case management support services for residents with CCA patients with complex physical and behavioral health issues • Advocate for health policy that promotes integration • Support telephonic and onsite psychiatric consultation for primary care providers serving those with behavioral health conditions • Provide OB/GYN services for women with chronic substance abuse issues • Provide culturally appropriate mental health services for the Hispanic/Latino community • Support educational opportunities on cultural psychiatry for Spanish speaking mental health providers • Continue Screening, Brief Intervention, and Referral to Treatment (SBIRT) in BIDMC's Emergency Department • Provide training for clinical providers on how to better integrate and coordinate behavioral health services across the system • Support evidence-based, community-based programs aimed at reducing stigma around behavioral health • Support evidence-based behavioral health interventions provided in community settings	**Facilitating Access to Behavioral Health and Substance Use** • The Bowdoin Street Health Center (BSHC) Behavioral Health Team provided 255 integrated Behavioral Health consultations in the Primary Care Clinic • BSHC Primary Integrated Behavioral Health Clinician provided 1,344 individual therapy sessions • BIDMC Social Work team held 12 support groups that met 192 times, serving a total of 1,281 patients in FY21 **Substance Use Services** • An additional social worker is collaborating with community providers to improve access to addiction services **Determination of Need (DoN) Community-based Health Initiative (CHI)** • Through BIDMC's Community-based Health (CHI) Initiative, 7 organizations were funded to address Behavioral Health • Each CHI Grantee created a logic model to outline project activities and goals • CHI Grantees participated in 7 Evaluation Learning Collaboratives to build their evaluation capacity

Goal 2: Reduce burden of opioid use		
Objectives	Activities	Progress, Outcomes, and Impact
• Increase the number of adults with substance issues who are appropriately monitored, assessed, and treated in Community Care Alliance (CCA) Clinics • Increase the number of patients receiving inpatient detox services	• Support the development of a BIDMC Bridge Clinic to promote access to services for those identified with SUD in hospital settings • Continue the Suboxone clinics in Health Care Associate (HCA) practices and the "bridging" clinic for non-HCA patients (2 sessions each) • Support the development of a BIDMC addictions advisory group • Support the expansion of the Dimock Inpatient Detox facility • Support/host Narcotics Anonymous at Bowdoin Street Health Center (BSHC)	• BIDMC hired a second attending psychiatrist for the Division of Addiction Psychiatry, ensuring that BIDMC patients can be seen in the Link Clinic for Opioid Use Disorder care 5 days a week • Continued to conduct buprenorphine waiver trainings, allowing more physicians to obtain their buprenorphine X-waivers • Added injectable buprenorphine to the formulary as another medication option for BIDMC patients • Translated patient education materials in multiple languages • Participated in the Opioid Use Disorder Initiative through the Mass Perinatal Quality Collaborative (MPQC) • Created guidelines for treating patients' pain while on Buprenorphine/ Naloxone (Suboxone) • Worked on an Opioid Prescribing Dashboard

Appendix E:
2023-2025 Implementation Strategy

Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

2022
Implementation Strategy

Implementation Strategy

About the 2022 Hospital and Community Health Needs Assessment Process

Beth Israel Deaconess Medical Center (BIDMC) is one of the nation's preeminent academic medical centers and is nationally recognized for its world-class clinical expertise, education and research. The medical center is also a Level 1 trauma center with a full range of medical/surgical, critical care, OB/GYN, and emergency services, and an extensive network of primary care and outpatient specialty care practices. BIDMC prides itself on its ability to combine exceptional, compassionate patient care with advanced medical knowledge, research, and technology in ways that allow it to achieve the best outcomes for its patients. BIDMC, in partnership with the BILH system, is committed to providing the very best care and strives to improve the health of the people and families in their service area.

The Community Health Needs Assessment (CHNA) and planning work for this 2022 report was conducted between September 2021 and September 2022. In conducting this assessment and planning process, it would be difficult to overstate BIDMC's commitment to community engagement and a comprehensive, data-driven, collaborative and transparent assessment and planning process. Altogether, this approach involved extensive data collection activities, substantial efforts to engage the medical center's partners and community residents, and thoughtful prioritization, planning, and reporting processes. Special care was taken across all the assessment's individual components to include the voices of community residents who are often left out of health assessments like this one, such as those who are unstably housed or homeless, who do not speak English, who are recent immigrants, who are in substance use recovery, or who experience barriers and disparities due to their race, ethnicity, gender identity, age, or other personal characteristics.

BIDMC collects a wide range of quantitative data to characterize the communities served across its Community Benefits Service Area (CBSA). BIDMC also gathered data to help identify leading health-related issues, barriers to accessing care, and service gaps. Whenever possible, data was collected for specific geographic, demographic, or socioeconomic segments of the population to identify disparities and clarify the needs for specific communities. The data was tested for statistical significance whenever possible and compared against data at the regional, Commonwealth, and national level to support analysis and the prioritization process. Authentic community engagement is critical to assessing community needs, identifying the leading community health priorities, prioritizing segments of the population most at-risk, and crafting a collaborative, evidence-informed IS. BIDMC employed a variety of strategies to help ensure that community members were informed, consulted, involved, and empowered throughout the assessment process. Across all four components, the assessment included 85 one-on-one interviews with key collaborators in the community, 22 focus groups with segments of the population facing the greatest health-related disparities, and community listening sessions that engaged 226 participants.

Prioritization and Implementation Strategy Process

Federal and Commonwealth community benefits guidelines require a nonprofit hospital to rely on their analysis of their CHNA data to determine the community health issues and priority cohorts on which it chooses to focus its Implementation Strategy (IS). By analyzing assessment data, hospitals can identify the health issues that are particularly problematic and rank these issues in order of priority. This data can also be used to identify the segments of the community that face health-related disparities or are disproportionately impacted by systemic racism or other forms of discrimination. Accordingly, using an interactive, anonymous polling software, BIDMC's CBAC and community residents, through the community listening sessions, formally prioritized the community health issues and cohorts that they believed should be the focus of BIDMC's IS. This prioritization process helps to ensure that BIDMC maximizes the impact of its community benefits resources and its efforts to improve health status, address disparities in health outcomes and promote health equity.

The process of identifying the hospital's community health issues and prioritized cohorts is also informed by a review and careful reflection on the Commonwealth's priorities set by the Massachusetts Department of Public Health's Determination of Need process and the Massachusetts Attorney General's Office.

BIDMC's IS is designed to address the underlying social determinants of health and barriers to accessing care, as well as promote health equity. The content addresses the leading community health priorities, including activities geared toward health education and wellness (primary

prevention), identification, screening, referral (secondary prevention) and disease management and treatment (tertiary prevention).

The following goals and strategies are developed so that they:

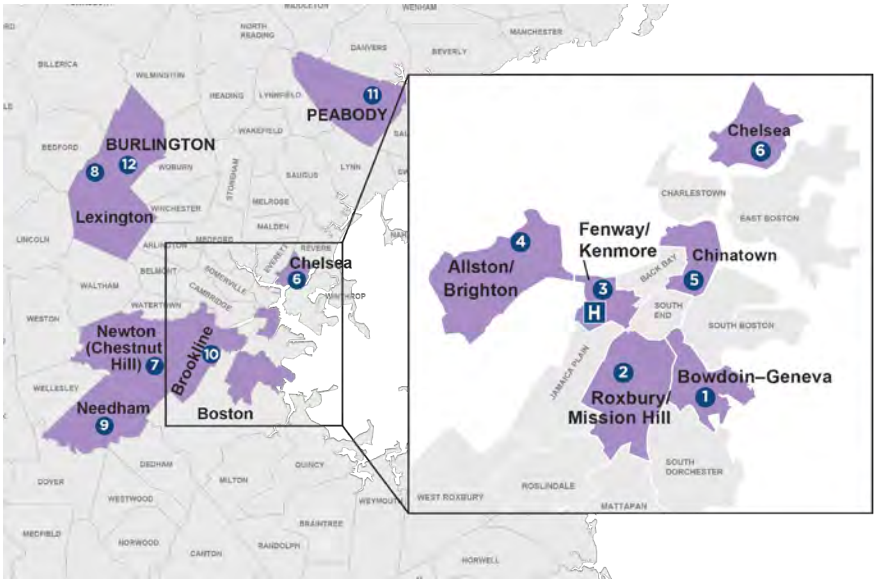
- Address the prioritized community health needs and/or populations in the hospital's CBSA.
- Provide approaches across the up-, mid-, and downstream spectrum.
- Are sustainable through hospital or other funding.
- Leverage or enhance community partnerships.
- Have potential for impact.
- Contribute to the systemic, fair and just treatment of all people.
- Are flexible to respond to emerging community needs.

Recognizing that community benefits planning is ongoing and will change with continued community input, BIDMC's IS will evolve. Circumstances may change with new opportunities, requests from the community, community and public health emergencies and other issues that may arise, which may require a change in the IS or the strategies documented within it. BIDMC is committed to assessing information and updating the plan as needed.

Community Benefits Service Area

BIDMC's CBSA does not include a contiguous set of geographic communities. Rather, per federal requirements, it is defined as the cities and towns that are part of the Community Care Alliance and/or where BIDMC operates licensed facilities. BIDMC's CHNA focused on identifying the leading community health needs and priority cohorts living and/or working within its CBSA. The activities that will be implemented as a result of this assessment will support all the people who live throughout the CBSA. In recognition of the considerable health disparities that exist in some communities in its CBSA, BIDMC focuses the bulk of its community benefits resources on improving the health status of those who face health disparities, experience poverty, or who have been historically underserved, living in the city of Chelsea and the Boston neighborhoods of Allston/Brighton, Bowdoin/Geneva, Chinatown, Fenway/Kenmore, Mission Hill and Roxbury.

While BIDMC operates licensed facilities in Burlington, Needham and Peabody, these service locations are in other BILH CBSAs. The Town of Burlington and the City of Peabody are located within Lahey Hospital and Medical Center's (LHMC) CBSA and the Town of Needham is located within Beth Israel Deaconess-Needham's (BID Needham) CBSA. As a result, the community benefits activities for these municipalities have been formally delegated to LHMC and BID Needham to ensure that activities are properly coordinated and address the identified needs.



Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

Community Benefits Service Area

- H Beth Israel Deaconess Medical Center
- 1 Bowdoin Street Health Center
- 2 The Dimock Center
- 3 Fenway Health
- 4 Charles River Community Health
- 5 South Cove Community Health Center
- 6 Beth Israel Deaconess Healthcare-Chelsea
- 7 Beth Israel Deaconess Healthcare-Chestnut Hill
- 8 Beth Israel Deaconess Healthcare-Lexington
- 9 BIDMC Cancer Center
- 10 BIDMC Pain Center
- 11 BIDMC Infusion Services, Peabody
- 12 BIDMC Infusion Services, Burlington

Prioritized Community Health Needs and Cohorts

BIDMC is committed to promoting health, enhancing access and delivering the best care for those in its CBSA. Over the next three years, the medical center will work with its community partners, with a focus on Chelsea and the Boston neighborhoods in its CBSA, to develop and/or continue programming to improve well-being and create a healthy future for all individuals and families. In recognition of the health disparities that exist for certain segments of the population, investments and resources will focus on improving the health status of the following priority cohorts and community health priority areas.

BIDMC Priority Cohorts

- Youth
- Low-Resourced Populations
- Older Adults
- Racially, Ethnically and Linguistically Diverse Populations
- LGBTQIA+
- Families Affected by Violence and/or Incarceration

BIDMC Community Health Priority Areas

Community Health Needs Not Prioritized by BIDMC

It is important to note that there are community health needs that were identified by BIDMC's assessment that were not prioritized for investment or included in BIDMC's IS. Specifically, addressing the digital divide (i.e., promoting equitable access to the internet) and supporting education across the lifespan were identified as community needs but were not included in BIDMC's IS. While these issues are important, BIDMC's CBAC and senior leadership team decided that these issues were outside of the medical center's sphere of influence and investments in other areas were both more feasible and likely to have greater impact. As a result, BIDMC recognized that other public and private organizations in its CBSA, Boston, and the Commonwealth were better positioned to focus on these issues. BIDMC remains open and willing to work with community residents, other hospitals, and other public and private partners to address these issues, particularly as part of a broad, strong collaborative.

Community Health Needs Addressed in BIDMC's IS

The issues that were identified in the BIDMC CHNA and are addressed in the hospital IS are housing issues, food insecurity, transportation, environmental justice/climate, economic insecurity, community safety, workforce development, small businesses, build capacity of healthcare workforce, navigation of healthcare system, linguistic access barriers, promotion/awareness of SDOH resources, diversify provider workforce, cost and insurance barriers, more peer-led services, addressing mistrust in healthcare, youth mental health, stress, depression, anxiety, isolation, impacts of violence & trauma, education (for communities, and for providers on how to best reach and treat them), stigma, racism (individual and systemic), culturally appropriate/competent health and community services, homophobia and transphobia, lack of education around diversity, equity, and inclusion (DEI), diversifying leadership, cross sector collaboration and responses, and linguistic access/barriers to community resources/services.

Implementation Strategy Details

Priority: Equitable Access to Care

Individuals identified a number of barriers to accessing and navigating the health care system. Many of these barriers were at the system level, meaning that the issues stem from the way in which the system does or does not function. System level issues included providers not accepting new patients, long wait lists, and an inherently complicated healthcare system that is difficult for many to navigate.

There were also individual level barriers to access and navigation. Individuals may be uninsured or underinsured, which may lead them to forego or delay care. Individuals may also experience language or cultural barriers - research shows that these barriers contribute to health disparities, mistrust between providers and patients, ineffective communication, and issues of patient safety.

Resources/Financial Investment: BIDMC will commit direct, community health program investments, and in-kind resources of staff time and materials. BIDMC will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services as well as on behalf of its community partners, such as the community health centers that are part of the Community Care Alliance, the health center network affiliated with Beth Israel Lahey Health and BIDMC.

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic and economic barriers.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Promote equitable care, health equity, health literacy, and cultural humility for patients across BIDMC and BILH's licensed and/or affiliated health centers, especially those who face cultural and linguistic barriers.	• Youth • Racially, ethnically and linguistically diverse populations • Older adults • Low-resourced populations • LGBTQIA+	• Sexual Orientation and Gender Identity (SOGI) Training and Data Collection • Center for Diversity, Equity, and Inclusion (DEI) • Interpreter Services	• # of BIDMC staff completing SOGI training • # of Underrepresented in Medicine clinicians recruited; % change over time • # of patients assisted • # of services provided • # of languages provided • # of DEI trainings	• Bowdoin Street Health Center • The Dimock Center • Fenway Health • Charles River Community Health • South Cove Community Health Center • The Student National Medical Association • The Latino Medical Student Association • Harvard Medical School • Found in Translation • Massachusetts Commission for the Deaf and Hard of Hearing	Chronic and Complex Conditions

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic and economic barriers.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Increase access to primary care and specialty care services, including OB/GYN and maternal child health services.	• Youth • Racially, ethnically and linguistically diverse populations • Older adults • Low-resourced populations • LGBTQIA+	• Community Care Alliance (CCA) and support for Community-based Primary and Specialty Care • Network/IT Integration and Access for CCA Health Centers • Care Connection • Boston Healthy Start Initiative • Residency Training Program	• # of specialists at CCA health centers • # of patients seen at affiliated Federally Qualified Health Centers (FQHCs) • # of visits provided at affiliated FQHCs • # of patients without insurance served at affiliated FQHCs • # of BIDMC specialists at affiliated FQHCs	• BILH Primary Care • Bowdoin Street Health Center • Charles River Community Health • Fenway Health • South Cove Community Health Center • The Dimock Center • Healthcare Associates (HCA)	Not Applicable
Address the health-related social needs (HRSN) of patients in order to support access to care.	Low-resourced populations	• Community Health Worker Program • BIDMC Social Work Department Services	• # of patients assisted with HRSN • # of patients provided with housing support • # of patients provided emergency food or gift cards • # of patients provided clothing	Bowdoin Street Health Center	Social Determinants of Health
Provide and promote career support services and career mobility programs to hospital employees.	BIDMC employees	• Pipeline programs • Career and academic advising • Hospital-sponsored community college courses • Hospital-sponsored English Speakers of Other Languages (ESOL) classes • Diverse talent promotion and acquisition	• # of employees who participated • # of employees who were promoted	• Bunker Hill Community College • Conexión, Inc. • Jewish Vocational Services (JVS) • The Partnership, Inc.	Social Determinants of Health - Jobs and Financial Security

Goal: Provide equitable and comprehensive access to high-quality health care services including primary care and specialty care, as well as urgent and emerging care, particularly for those who face cultural, linguistic and economic barriers.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Promote access to health insurance, patient financial counselors, and needed medications for patients who are uninsured or underinsured	Low-resourced Populations	• Financial Counseling • Pharmacy Programs	• # of patients screened for eligibility • # patients enrolled into entitlement programs • # patients enrolled in Masshealth • # patients enrolled in Health Safety Net (HSN)	• BILH Pharmacy	Chronic and Complex Conditions
Advocate for and support policies and programs that address healthcare access.	Community residents	To be determined	• # of policies reviewed • # of policies supported	BILH Government Relations	Not Applicable
Support research aimed at providing more equitable care for patients and community members.	BIDMC patients and community residents	Center for Diversity, Equity, and Inclusion	Amount of funding dedicated to disparities research	• The Student National Medical Association • The Latino Medical Student Association • Harvard Medical School	Not Applicable
Provide and support residents with transportation access, public safety, emergency care, public health and emergency preparedness.	BIDMC patients and Commonwealth residents	• Medical and Critical Care Transportation • Trauma, Emergency Management, and Public Health Surveillance • Public Safety	• # of patients assisted • # taxi or ride-sharing vouchers provided	• Boston Emergency Management Office • Boston Emergency Medical Services • Boston Fire Department • Boston Public Health Commission • Conference of Boston Teaching Hospitals • MA Department of Public Health • Medflight • Medical Academic and Scientific Community Organization (MASCO)	Social Determinants of Health

Priority: Social Determinants of Health

The social determinants of health are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions influence and define quality of life for many segments of the population in the CBSA. Research shows that sustained success in community health improvement and addressing health disparities relies on addressing the social determinants of health that lead to poor health outcomes and drive health inequities. The assessment gathered a range of information related to economic insecurity, education, food insecurity, access to care/navigation issues, and other important social factors.

There is limited quantitative data in the area of social determinants of health. Despite this, information gathered through interviews, focus groups, survey, and listening sessions suggested that these issues have the greatest impact on health status and access to care in the region - especially issues related to housing, food security/nutrition, and economic stability.

Resources/Financial Investment: BIDMC will commit direct, community health program investments, and in-kind resources of staff time and materials. BIDMC will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services as well as on behalf of its community partners, such as the community health centers that are part of the Community Care Alliance, the health center network affiliated with Beth Israel Lahey Health and BIDMC.

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support evidence-based programs and strategies to reduce homelessness, reduce displacement, and increase home ownership by low-income individuals and families.	• Youth • Racially, ethnically and linguistically diverse populations • Older adults • Low-resourced populations • LGBTQIA+ • Families affected by violence and/or incarceration	Investments in housing programs to stabilize or create access to affordable housing	• # of participants and their demographics • Housing stability[1] • # of youth housed • # of housing policies passed	• Bridge Over Troubled Waters • Metro Housing|Boston • Asian Community Development Corporation (CDC) • BAGLY, Inc. • City Life/Vida Urbana • Chinese Progressive Association • Fenway Community Development Corporation (CDC) • Nuestra Community Development Corporation (CDC) • Opportunity Communities • Innovative Stable Housing Initiative (ISHI) • Additional grantees TBD	Not Applicable

1. Data are being collected on housing situation, agency, and affordability. Data are being collected on two aspects of individuals' housing situations: description of their housing situation and satisfaction with their housing situation. Agency is measured through control and confidence related to housing. To measure affordability, participants are asked which, if any, household expenses they have had to forgo in order to pay for their housing in the last 3 months.

Goal: Enhance the built, social, and economic environment where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support evidence-based programs, strategies, and partnerships to increase employment and earnings and increase financial security.	• Youth • Racially, ethnically and linguistically diverse populations • Older adults • Low-resourced populations • LGBTQIA+ • Families affected by violence and/or incarceration	• Investments in jobs and financial security programs to strengthen the local workforce and address underemployment • Community hiring	• # of participants and their demographics • Adult Hope Scale[2] • Financial capabilities • # of community residents hired	• Bridge Over Troubled Waters • Community Servings • English for New Bostonians • La Colaborativa • Metro Housing|Boston • Sociedad Latina • African Bridge Network • Jewish Vocational Services • Operation ABLE • Roxbury Community College • YMCA – Training, Inc. • BILH Workforce Development • Additional grantees TBD	Not Applicable

2. The self-efficacy measure is defined as believing that you can overcome obstacles and get things done. To measure this outcome, grantees are using a version of the Adult Hope Scale (adapted by the American Psychological Association (APA)). There are six questions: three questions that measure Agency, or goal directed energy, and three questions that measure Pathways, or the planning to accomplish goals. Each question is scored on a scale of 1-8, from definitely false (1) to definitely true (8). The scores for all six questions can be summed to calculate a Hope score. Subscale scores for Agency and Pathways may also be calculated in or order to examine both dimensions of "Hope" independently. Specifically, the Agency and Pathways subscales are scored by summing the score (1-8) of three questions, out of a possible 24 each. The full Hope score is calculated by adding all 6 responses together out of 48.

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Promote thriving neighborhoods and enhance community cohesion and resilience.	• Youth • Racially, Ethnically and Linguistically Diverse Populations • Older Adults • Low-resourced Populations • Families Affected by Violence and/or Incarceration	• Healthy Neighborhoods Initiative • The Wellness Center at Bowdoin Street Health Center • Village in Progress (VIP) • Neighborhood Trauma Team • Placemaking activities and neighborhood improvement	• Collective relationships and cohesion • Impact of community-driven/led investments • # of neighborhood incidents responded to • # of therapeutic sessions provided • # of new community leaders	• We're Here for You: Fenway/Kenmore • Healthy Bowdoin Geneva • Chelsea Healthy Neighborhoods Initiative • Chinatown HOPE • Allston/Brighton, Mission Hill, and Roxbury Collectives TBD • Boston Police Department • Boston Public Health Commission • Family Nurturing Center • Greater Four Corners Action Coalition • Louis D. Brown Peace Institute • Medical Academic and Scientific Community Organization (MASCO) • St. Peter's Teen Center	Mental Health and Substance Use
Increase mentorship, leadership, training, and employment opportunities for youth and young adults residing in the communities BIDMC serves.	• Youth (including youth with physical and cognitive disabilities) • Racially, ethnically and linguistically diverse populations • Low-resourced populations	• Youth summer jobs program • BIDMC Youth Advisors	• # of youth involved • Job skills • Public health skills and knowledge	• Action for Boston Community Development (ABCD) • Boston Private Industry Council • Bowdoin Street Health Center • Boys and Girls Club of Boston • Mary K. Lyon School • Massachusetts Commission for the Blind • Sociedad Latina • Steps to Success • YMCA of Greater Boston	Not Applicable

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Advocate for and support policies and programs that address the social determinants of health.	Community residents	To be determined	• # of policies reviewed • # of policies supported	BILH Government Relations	Not Applicable
Conserve natural resources, reduce carbon emissions, and foster a culture of sustainability to create a healthy environment for residents.	• BIDMC patients and employees • Community residents	Environmental Sustainability	• Greenhouse gas emissions • % local food and beverage spend • Waste diversion[3]	• A Better City • Boston Green Academy • City of Boston's Green Ribbon Commission • Commonwealth Kitchen • Eversource • Healthcare Without Harm • Practice Green Health • MA Department of Environmental Protection • Sodexo • US Environmental Protection Agency	Not Applicable

3. Defined as non-hazardous solid waste diverted from landfill or incineration through reduction, reuse, recycling, compost, or use of future technologies.

Goal: Enhance the built, social, and economic environments where people live, work, play, and learn in order to improve health and quality-of-life outcomes.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Build community awareness, advocate for policy change, and provide supportive care for victims of violence and trauma.	Families Affected by Violence and/or Incarceration	The Center for Violence Prevention and Recovery (CVPR)	• # sexual assault victims receiving services • # of services provided to sexual assault victims in the Emergency Department (ED) • # education and outreach services • # of safe bed overnight stays • # of healing circles	• Boston Area Rape Crisis Center • Boston Medical Center • Brigham and Women's Hospital • Cambridge Health Alliance • Casa Myrna • Conference of Boston Teaching Hospitals (COBTH) Domestic Violence Council • Jane Doe, Inc. • Louis D. Brown Peace Institute • Mass General Hospital • RIA, Inc. • SANE • Sexual Assault Unit of Disabled Persons Protection Commission (DPPC) • The Network/La Red • Victim Rights Law Center	Mental Health and Substance Use
Promote healthy eating and active living by increasing opportunities for physical activity and providing healthy food resources to patients and community residents.	• Youth • Racially, ethnically and linguistically diverse populations • Low-resourced populations • Older adults	• The Wellness Center at Bowdoin Street Health Center • Grocery store gift card distribution program • Fitness in the City • Explore installation of Freight Farms™	• # of participants • # of units of food produced and distributed • # of gift cards distributed • $ amount of gift cards distributed • # of families receiving gift cards • Food insecurity status	• About Fresh • Boston Children's Hospital • Bowdoin Street Health Center • Champion Tae Kwan Do Center • Fair Foods • Sportsmen's Tennis Club • The Dimock Center • Trustees of Reservations	Not Applicable

Priority: Mental Health and Substance Use

Anxiety, chronic stress, depression, and social isolation were leading community health concerns. The assessment identified specific concerns about the impact of mental health issues for youth and young adults, the mental health impacts of racism, discrimination, and trauma, and social isolation among older adults. These difficulties were exacerbated by COVID-19.

In addition to the overall burden and prevalence of mental health issues, residents identified a need for more providers and treatment options, especially inpatient and outpatient treatment, child psychiatrists, peer support groups, and mental health services.

Substance use continued to have a major impact on the CBSA; the opioid epidemic continued to be an area of focus and concern, and there was recognition of the links and impacts on other community health priorities, including mental health, housing, and homelessness. Individuals engaged in the assessment identified stigma as a barrier to treatment and reported a need for programs that address common co-occurring issues (e.g., mental health issues, homelessness).

Resources/Financial Investment: BIDMC will commit direct, community health program investments and in-kind resources of staff time and materials. BIDMC will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services as well as on behalf of its community partners, such as the community health centers that are part of Community Care Alliance, the health center network affiliated with Beth Israel Lahey Health and BIDMC.

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use issues and conditions.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Support and implement evidence-based programs that increase access to high-quality and culturally and linguistically appropriate mental health and substance use services.	• Youth • Racially, ethnically and linguistically diverse populations • Low-resourced populations • Older adults • LGBTQIA+ • Families affected by violence and/or incarceration	• Investments in community behavioral health services through screening, monitoring, counseling, navigation, and treatment • Community-based Primary and Specialty Care (Support for licensed and/or affiliated community health centers) • Screening, Brief Intervention, and Referral to Treatment • Integrative Care Model • Collaborative Care Model • Opioid Care Committee • The Dimock Center substance use clinical stabilization services	• # of participants and their demographics • Mental health symptoms (PHQ-8; PHQ-9; PSYCHLOPS) • Stigma (Recovery Assessment Scale (RAS-DS) and General Help-Seeking Questionnaire (GHSQ) • # of patients assisted • # of therapy sessions • # of integrated BH consultations • # of practices	• Boston Chinatown Neighborhood Center • Fathers' Uplift • Greater Boston Chinese Golden Age Center • The Family Van • Additional grantees TBD • Bowdoin Street Health Center • Charles River Community Health • Fenway Health • South Cove Community Health Center • The Dimock Center • Health Care Associates (HCA) • BILH Behavioral Services • BILH Primary Care	Equitable Access to Care

Goal: Promote social and emotional wellness by fostering resilient communities and building equitable, accessible, and supportive systems of care to address mental health and substance use issues and conditions.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/ WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Advocate for and support policies and programs that address mental health and substance use.	Community residents	To be determined	• # of policies reviewed • # of policies supported	BILH Government Relations	Not Applicable
Implement trauma-informed care (TIC) principles and other prevention strategies to improve care for all, especially those with a history of adversity.	• Racially, ethnically and linguistically diverse populations • LGBTQIA+ • Families affected by violence and/or incarceration	Expansion of Trauma-informed care (TIC)-training across hospital	• # of hospital departments that have received TIC training • Staff knowledge and skills	• Louis D. Brown Peace Institute • BIDMC Social Work Department	Equitable Access to Care

Priority: Chronic and Complex Conditions

Chronic conditions such as cancer, diabetes, chronic lower respiratory disease, stroke, and cardiovascular disease contribute to 56% of all mortality in the Commonwealth and over 53% of all health care expenditures ($30.9 billion a year). Perhaps most significantly, chronic diseases are largely preventable despite their high prevalence and dramatic impact on individuals and society.

Resources/Financial Investment: BIDMC will commit direct, community health program investments, and in-kind resources of staff time and materials. BIDMC will also generate leveraged funds through grants from public and private sources on behalf of its own programs or services as well as on behalf of its community partners, such as the community health centers that are part of Community Care Alliance, the health center network affiliated with Beth Israel Lahey Health and BIDMC.

Goal: Improve health outcomes and reduce disparities for individuals at-risk for or living with chronic and/or complex conditions and caregivers by enhancing access to screening, referral services, coordinated health and support services, medications, and other resources.

STRATEGIES	COHORT(S)	INITIATIVES TO ADDRESS THE PRIORITY	METRICS/WHAT WE ARE MEASURING	IDENTIFIED PARTNERS	SECONDARY PRIORITY
Provide preventive health information, services, and support for those at risk for complex and/or chronic conditions and support evidence-based chronic disease treatment and self-management programs.	• Racially, ethnically and linguistically diverse populations • Low-resourced populations • Older adults • LGBTQIA+	• The Wellness Center at Bowdoin Street Health Center • BILH Pharmacy Assistance Programs • Community-based Diabetes Prevention and Treatment Programs • Cancer Patient Navigators • Support Groups • Lung Cancer Early Detection Screening • Multilingual Cardiovascular Clinics • Implement BILH Diabetes Disparities initiative strategies, as appropriate	• # of patients • # of encounters • % of Federally Qualified Health Center (FQHC) patients whose diabetes is controlled (HBA1C <9%) • % of FQHC patients whose hypertension is controlled • # of support groups • # of patients attending support groups • # of patients receiving early detection lung cancer screening	• AIDS Action Committee • BILH Primary Care • BILH Pharmacy • Boston Public Health Commission • Community Servings • Dana Farber Cancer Institute • Bowdoin Street Health Center • Charles River Community Health • Fenway Health • South Cove Community Health Center • The Dimock Center • Joslin Diabetes Center • Mount Auburn Hospital • Massachusetts Department of Public Health • New England AIDS Education and Training Center	Equitable Access to Care

General Regulatory Information

Contact Person:	Robert Torres, Director of Community Benefits
Date of written plan:	June 30, 2022
Date written plan was adopted by authorized governing body:	September 21, 2022
Date written plan was required to be adopted	February 15, 2023
Authorized governing body that adopted the written plan:	Beth Israel Deaconess Medical Center Board of Trustees
Was the written plan adopted by the authorized governing body on or before the 15th day of the fifth month after the end of the taxable year the CHNA was completed?	☑ Yes ☐ No
Date facility's prior written plan was adopted by organization's governing body:	September 18, 2019
Name and EIN of hospital organization operating hospital facility:	Beth Israel Deaconess Medical Center 04-2103881
Address of hospital organization:	330 Brookline Ave. Boston, MA 02115

Beth Israel Lahey Health

Beth Israel Deaconess Medical Center

bidmc.org